			artment of Health and Me	ental Hygiene Reg. No.	2008 27001
Physi		1. Decedent's Name (First, Middle, Last)  Goldie Irene BOWMAN	1 2	2. Date of Death Month Lugust 9, 2	3. Time of Death 3:30 p M
/Med Exam		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		County of Death
ark.		Homewood at Williamsport  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)	Williamsport )		Jashington  9. Birthplace (State or Foreign
Funera Directo		215–18–1466 1 M 2 St F 91 Yrs.	Months Days Hours Min.	B. Date of Birth (Month, Day, Year) Oct. 17, 19	916 Maryland
land w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Literature	ocation		10d. Inside City Limits
e Mary a-f sho	cto	Maryland Washington Hagersto	own		1 ☐ Yes 2 🔀 No
with the a or 28	Director	10e. Street and Number 102 Stone Croft Apt 210A	10f. Zip Code 21742		en of What Country?
death	Funeral	-	Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri		4. Race - American Indian,
71 213-UU36 within 72 hours after death with the Maryland fiene. than "natural", or frems 23a or 28a-f show than Madical Exempler must be notified at	by Fu	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give  3 ☒ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Black, White, etc. Spec <i>ify:</i> white
72 hours aft "natural", or	eted b	15. Decedent's Education 16a. Dece	edent's Usual Occupation	16b. Kind	d of Business/Industry
Vithin 7	Completed	Elementary/Secondary (0-12)   College (1-40r5+)	e kind of work done during most of working DO NOT use retired) USEWITE		er own home
land Z	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (I	First, Middle, Maiden S	Gurname)
rylal	70	Andrew V. Baker		Goldie Mae	
Daltimore, Maryland 21215-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Marical Eventhale must be notified at			ing Address <i>(Street and Number or Rural I</i> 4 St Paul Road, Clea		
Ore,		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposemetry, cre	osition (Name of Date Manatory or other place) August	14.	ation - City or Town, State
altimo mit. Pages partment o portant: If i y injury or		4 □ Donation 5 □ Other (Specify) Cedar La	wn Memorial 20	08 Hage:	rstown, Maryland
Deparmi Deparmi any ir	N N		15 East Wilson Blvd		
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or i	respiratory arrest,	Approximate Interval Between Onsix and Death
Physician /Medica		Immediate Cause (Final disease or condition resulting in death)  a. Due 6 (or as a consequence of):	OKE		3 D465
Examine		+10-76-11/CC16	nosis		YEARS
uted I nsit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events			•
orou, cate be executed physician and the burial-transit	Exal	resulting in death) Last  C.  Due to (or as a consequence of):			
ficate be executed physician and the burial-transit	dical	d			
th certif	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mosths?  1 □ Live birth 2 □ Fetal death 3	□ Ectopic pregnancy	23	3d. Date of delivery
To the Hospital or Attending Physician: The law requires that the death certification within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending it completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me		Other (specify)		Month Day Year
s that t gned by e detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.	23e. Did tobacco use	e contribute to the cause of death?
v requires to been signer should be a	ted k	HIZHERMEN I DEMESTIA JE	Voit	1 ☐ Yes 2 🐧	No 3 Probably 4 Unknown
he law e has b ge 2 st	Completed	_ CHANIC /LENGE /UJUFFICE	iency	24a. Was an autopsy performed2	24b. Were autopsy findings available prior to completion of cause of death?
ian: Ti rtificati ctor, pa	Be Co	25. Was case referred to medical	26. Place of Death (	performed? 1 □ Yes 2 A No Check only one)	1 ☐ Yes 2 ☐ No
Physic This ce al direc	ြို	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie  27. Mapper of Death 28a. Date of Injury 28b. Time of		5 ☐ Residence 6	
nding ath. r: After e funer	ation	27. Mapper of Death  1	of 28c. Injury at 28i Work?  M 1 □ Yes 2 □ No	d. Describe how injury	occurred
or Atte fter deg lirector	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, ste building, etc. (Specify)	reet, factory, office 28	f. Location (Street and City or Town, State)	Number or Rural Route Number,
spital of nours a neral D		29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, deal	th occurred at the time, date and place, an	nd due to the cause(s) a	and manner as stated.
the Ho hin 24 I the Fu npletely	fedical	(Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred	d at the time, date and p	place, and due to the cause(s)
vitt vitt	Σ	29b. Signature force the Moertifier	29c. License number	29d. Date	signed (Month, Day, Year)
		30, Name and address of person who completed cause of death (Item 23a) (Type,	Proti 6	74	(1, 1) -
5H-5		STOPHWE-METZNEN, MA 13424 31. Date fled (Month, Day, Year) 12 Degistrar's Signature	la live tracel	15theur,	Md 21742
St Regist	tate trar	AUG 1 1 2008	2016		

State Registrar

AUG 1 1 2008



30. Name and address of person who completed cause of death (ttom 23a) (Type, Print)

663

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10, 2008 **Physician** BAYNARD AUGUST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ruxton Health of Denton Caroline Denton If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5, Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√□ F 215-44-7006 Director 63 Nov. 27. 1944 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1-√Yes 2 No Director Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? South Eighth Street Apt. 505 21629 United States of America Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritai Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes Ž No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u> Line Worker</u> Food Processing of the state of th other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Emerson Baynard Beatrice Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: if item 27 is any injury or other trau once. Sharon Downes Daughter PO Box 599, Clayton, Delaware altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/11/2008 4 □ Donation 5 □ Other (Specify) Capitol Crematory Dover, Delaware 21. Signor re of Juneral Service Licenses Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, or comshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG **Physician** /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 23d. Date of delivery 3 ☐Ectopic pregnancy 5 Other (specify) P.0. ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by CONGESTIVE HEART FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CHRONIC OBSTRUCTIVE PULMONARY DISEASE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has ral director, page 2 autopsy perform To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 063063 29d. Date signed (Month, Day, Year) 44608711,200829b. Signature and title of certific

State Registrar 30. Name and add

RMALO

DHMH 17 Rev 1/2001

DAFFIN LANE DENTON, MD 2/629

of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 7,  $a^{M}$ 2008 9:30 Louis Edward Blakeley, August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Cecil Elkton Union Hospital of Cecil County If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Yrs. 219-28-5895 1 K M 2 □ F 81 1927 Maryland Director 28, Feb. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with U.S.A. 7 Spring House Court 21911 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 21 No Specify. ģ White 3₺Widowed 4 Divorced Completed 16b. Kind of Business/Industry Harford County of Education 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) filed within 72 Board (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. tem 27 is marked other than Seven Years Custodian Bel Air, Maryland land 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Elsie Curry Oliver Blakelev and 2 should other traumatic P Maryl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley M. Kornegay (daughter) 7 Spring House Court, Rising Sun, MD 21911 Department of Health important: if item 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 20a, Method of Disposition 9 1 Burial 2 □ Cremation 3 □ Removal from State 08/12/08 West Nottingham Cemetery Colora, Maryland 4 ☐ Donation 5 ☐ Other (Specify) injury 21. Signature of Funeral Service License Name and Address of Facility ee A. Patterson & Son Funeral Home, P.A. 22. Nam Lee worker Perryville, Maryland 21903-0766 ne/mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause in a ach line. Do not enter t Approximate Interval Between Onset and Death Immediate Cause (Final D **Physician** /Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9□Unknown 9 ☐ Unknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performe No No 1 TYes 1∐ Yes 28 No Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA P funeral 27. Manner of Death 1 X Natural 2 Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After (Month, Day Year) 5 ☐ Pending To the Hospital or Attendii within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation М 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only ledical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ame and address of person who completed cause of death (Item 23a) (Type) 31. Date filed (Month State Registrar

08-05823 Johnathan Courtr				oe or Pri ate of Ma		/ Depai		Heal	th and			giene		2	00	8 2700
Physicia: Medical Examin	n/	Registrar 1. Decedent's Nam		,	Danasa		uncate of	Deal				Date of De Month July 30,	Dav	Year		3. Time of Death 0229 hrs
pro-		4a. Facility Name (	if not institution					4b. City, <sup>*</sup> Chev	Town, or Li	ocation o		:	40	c. County o		s
Funeral Director		5. Social Security I		6. Sex	_	ge (In yrs. la	st birthday)	Month	er 1 Year	If Unde Hours	_		18		9. Birth Foreign Cour	place (State or Maryland
any	- 1-	213-29- Usual Residence of 10a. State		1 2 10 2	'	10c. City,	Town or Local	- L			1	Aug.	<del>-03</del>	1980		10d. Inside City Limits
*	Director	MD 10e. Street and Nu		e Georg	ges	Di	strict	Heis 10f. Zip		<u> </u>			10g. Cit	izen of Wh		1 X Yes 2 No
with the M is 23a or 2 e notified	ra Dire	1700 D	ennis		as Deceder	nt Ever in U.S	S. 13. Wa		0747 ent of Hisp	anic Orig	jin? ( Spec	ify Yes or I	No-	U.S		an Indian, Black,
after death al", or iten	by Funeral	1 X Never Marri 3 Widowed		arried		s? 2 <b>X</b> No	1		fy Cuban,		Puerto Ri	can, etc.)		White Specify:		k
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed b	15. Decedent's E Elementary/Sec			est grade co lege (1-4 or			ost of wo	Occupation				16b.	Kind of Bus	siness/In	dustry
15-003 filed within Hygiene. d other th		17. Father's Name	(First, Middle		3		Studer	ıt	18		,			Educa Surriame)		α
D 212. should be and Menta 77 is marke	To Be	Ralph I	ame/Relations	hip (Type, Pri		-	19b. Mailin			and Num	ber or Ru		lumber, C			
ore, M ges I and 2 t of Health : If item 2	Ì	Tina A 2  20a. Method of Dis  1 X Burial 2			ner	State C	Place of Disport rematory or of	sition (Na her place	me of ceme	etery,		Date	20c.		City or T	own, State
Baltim permit. Pa Departmen Important	ŀ	4 Donation 5		Licensee	240	Was	hingto									
Physician /Medical	1	23a. Part I. Enter the failure. List or	nly one cause	on each line.												D.C. 20012 Approximate Interval Between Onset and Death
xaminer		Immediate Cause or condition resulti	ng in death)	-		sequence of	):									
cuted mnd transit	Examiner	if any, leading to ir cause. Enter Und (Disease or injury events resulting in	nmediate erlying Cause that initiated	c.		sequence of								[4		
0, te be execute ysician and burial - trar		UNPENDED	)	X AMEN #80	DED DETFH	8-8-0	8.BMW.I	<u> 10Co</u>					Loc	N. Data of	4-15	
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		23b. Was decedent past 12 month:	s?	he 1 4	Live birth	ome of pregnation	2 Fe	etal death ther (Spe		Ectopic	pregnand	Ç <b>y</b>	23	3d. Date of Month	D	ay Year
rrds, P.O. I	2	Part II. Other sign	ificant condit	tions contrib	uting to dea	ath but not re	sulting in the	underlyin	g cause giv	ven in Pa	irt I.		_	vuse contri		he cause of death? ably 4 Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in the funeral director.	Completed								00.51			1 <b>✓</b> Ye	topsy rformed?	p d		opsy findings available ompletion of cause of 2 No
ion of Vital Recteding Physician: The eath. for: After this certificate the funeral director, page	٥	25. Was case reference examiner?  1 ✓ Yes	2 No	Hospital:	1 Inpat		ER/Outpatien	3	3071	Other4	Nursing	Home 5	_,,	ence 6	Other:	
Sion o' Attending death. sctor: Afte	Certification:	<ul><li>27. Manner of Dea</li><li>1 Natural</li><li>2 Accident</li></ul>	5 Pend	ding stigation	n. Date of In (Month, Day Il 29, 2008	Year)	28b. Time of 1819 hrs			es 2 🗸	No O	perator	of moto	jury occurre prcycle in	n collis	
Division  Hospital or Attend 24 hours after death Funeral Director:		3 Suicide 4 Homicide 29a. Certifier	dete	rmined (S	pecify) M	ajor Road	me, farm, stre	/			R	or Town oute 214	i, State) at Enter	prise Roa	d, Larg	
To the Hosp within 24 hc To the Fun completely it	edica	(Check only one) 2	Medical Exa			amination an		tion, in m	y opinion,	death oc			ate and pl	lace, and d	ue to the	cause(s)
1	2	29b. Signature and	ed 2	er (					c. License O.C.N					. Date signe y 31, 20		th, Day, Year)
		30. Name and add	·	who complete sistant Med		,	<sup>23a)</sup> 111 Penn \$	Street, I	Baltimor	re, MD	21201					
Sta Registr	te ar	31. Date filed (Mor	JG Day Year	2008	Ed.a.	rar's Signatu	e April	de s								

DHMH 17 Rev 1/2001

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Per me, g882\_08/29/08dhb.
Registrar Registrar Registrar Registrar Reg. No. 2 0 0 8 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 3, **Physician** 8:45 P M Libbie Berman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Hebrew Home of Greater Washington Rockville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) 5. Social Security Numbe **Funeral** Days Hours Months 1 ☐ M 2 🗙 F 1913 Aug. 8, Lithuania 94 Director 186-44-6510 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anne. 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 X Yes 2 No Director MD Rockville Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 U.S.A. 6121 Montrose Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ∐ Yes 2 ⊠ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Joseph Cantor Leah Promneck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rockville, MD 20850 Mincy Neil - Daughter 602 Tegner Way 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 N Removal from State 8/6/2008 Adath Jeshurun Pittsburgh, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused to eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) IASTRO-1 STINAL **Physician** /Medical Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY CHECK Due to (or as a consequence of) Examiner law requires that the death certificate be executed the attending physician and the for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? Day Year Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 25 No this certificate 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 10 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 □ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 🖆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif au un

State Registrar

31. Date filed (Month, Day, Year)

(Year) 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lernen

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2008 27007

Arthur Robert Clark State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day August 12, 2008 0644 hrs al Examiner Arthur Robert 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Somerset 26908 Mt. Vernon Rd Princess Anne If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 227-25-2761 1 XM 2 F 41 02-01-1967 Virginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Yes 2 No hours after death with the Maryland Maryland Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26908 Mt. Vernon Road Ξ 21853 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married Yes Yes 2 X No specify: Specify: White Widowed 4 X Divorced If Yes, Give Year ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) d Mental Hygiene. s marked other than "r ic event, the Medical E College (1-4 or 5+) within 72 MD 21215-0036 Refrigeration Supply none General <u>Manager</u> 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Himportant: If item 27 is marked or injury or other traumatic event, ## Be Arthur R. Clark Betty Bentz 19a. Informant's Name/Relationship (Type, Print) (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Bentz/mother Road. Princess Anne, MD 218 te 20c. Location - City or Town, State Mt. Vernon MD 21853 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 2 Cremation 3 Removal from State Salisbury Crematory Other Spe 8/15/2008 Salisbury, Maryland Donation 5 22. Name and Address of Facility Hinman Funeral Home Signature of Funera M00295 11673 Somerset Ave. Princess As 2Ba. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or M00295 Approximate Interva hysician Between Onset and Medical Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions If any, leading Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical AMENDED 23a, pt.II,27 per me g883 9-8-08 vt X UNPENDED attending physician or use as the burial Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o à ۵ 1 Yes 2 ✔ No 3 Probably 4 Unknown Chronic Obstructive Pulmonary Disease Completed Records, 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy icate has death? performed? ✓ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be examiner' Hospital: 1 Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene this 1 V Yes No After 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: 1 X Natural Pending 1 Yes 2 No within 24 hours after death To the Funeral Director: completely filled in by the f 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 13, 2008 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month) strar's Signature State 1 1 g 2008 Registra

ORIGINAL

A-OCME

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 2008 9 7:40 AUGUST CLIPP SR. DONALD LEROY 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) WASHINGTON KEEDYSVILLE 6616 HARDWOOD LANE 8. Date of Birth (Month, Day, Year) JAN. 30, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days 1X M 2□ F MÁRYLAND 1942 66 216-38-2227 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No KEEDYSVILLE MARYLAND WASHINGTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. <u> 21756</u> 6616 HARDWOOD LANE 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐Yes 2 Yes, Give 2**X** No 1 □ Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) <u>ALUMINUM MANUFACTURE</u> ELECTRICIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FRANCES IRENE NALLY RICHARD EDWARD CLIPP 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21756 6616 HARDWOOD LANE, KEEDYSVILLE, MARYLAND JANICE L. CLIPP/SPOUSE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □Removal from State MARYLAND 8/13/2008 KEEDYSVILLE, 4 Dopation 5 Other (Specify FAIRVIEW CEMETERY 22. Name and Address of Facility BAST-STAUFFER FUNERAL HOME 21. Signature of F Paul M. Dean 21713 7606 Old National Pike, Boonsboro, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐ Unknown 2 No 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 26. Place of Death (Check only one, Hospital 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 28d. Describe how injury occurred

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a. State

**Funeral** 

Director

28a-f show

Director

Funeral

à

Be Completed

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Examiner Physician/Medical ð Completed

cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit death certificate be After this certificate funeral director,

Division or Vital Records, P.O. Box 68760

or Attending Physician; within 24 hours after death

To the Funeral Director: completely filled in by the f To the Hospital

Be ဥ Certification:

15H-20

State

25. Was case referred to medical 1 Yes 2 No 27. Manger of Death Natural 2 Accident 3 Suicide

4 Homicide

(Check only one)

29a. Certifier

Medical

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

28b. Time of

М 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c.

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

of death (Item 23a) (Type, Print) 30. Name and address of per on wh

2008

31. Date filed (Month, Day, AUG 1 2

29b. Signature and title of certifier

32. Redistrar's Signature

Registrar

		1	For Amend#23a Per PHY State Part II 8/6/08	State of Mai	yland DEPT (	/ Depa MH <i>Cer</i>	irtment of H tificate of L	leaith and iv D <i>eath</i>	ientai Hy	gierie, Reg. No.	2008	27009
	Dhuaiais		Decedent's Name (First, Middle, Last)						2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic	al -	hatherine	L. Ch	apr	nar		Location of Death	08	40.0	County of Dea	x8 09 x4 ™
	Examin	er	4a. Facility Name (If not institution, give: ANNE ARUNDEL MEDI		2		ANNAPOL]				NE ARU	
-	Funeral		5. Social Security Number 6. Sec	7. Age	(In yrs. las		If Under 1 Year Months Days		8. Date of Bir (Month, Da MAY 16	th ly, Year)	9. Bir	thplace (State or Foreign ountry) SHINGTON D.C.
L	Director	-	5/8 34 4332	M 25XF	85	Yrs.			MAY 16	,192.	3 WAS	SHINGION D.C.
	ow at	1-	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	e Manya-f sh	ctor	MARYLAND ANNE ARU	JNDEL	LOTH	IAN						1 ☐ Yes 2 No
	vith th	Dire	10e. Street and Number	ZT TANTE			10f. Zip Code 20711			-	en of What C ED STAT	
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral Director	4507 WINDING BROOM	12 Was Decedent Fr	ver in U.S.	13. \		lispanic Origin? (Sp an, Mexican, Puerto			14. Race - Am Black, Whi	erican Indian,
9	or iten	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give	0		r Yes, specify Cuba 1 □ Yes 2 1 No	Specify:	Hican, etc.)		Specify: WH]	
21215-0036	hours ural",	Completed by	3 🔀 Widowed 4 □ Divorced  15. Decedent's Edu	If Yes, Give Year or Dates:	-	16a Dece	dent's Usual Occup	ation			WIT] nd of Business	
-51	15. Decedent's Education  (Specify only highest grade completed)  (Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)											
212	Elementary/Secondary (0-12) College (1-40r 5+)  12 O HOMEMAKER  HOME  18. Mother's Name (First, Middle, Maiden Surnam											
gug	be file	Be	17. Father's Name (First, Middle, Last)					CHRISTAP		RTON	Surname)	
Maryland	should nd Mei marke	2	JOHN JOST  19a. Informant's Name/Relationship (7)	/pe. Print)		19b. Mailir	ng Address (Street	and Number or Ru			r Town, State,	Zip Code)
	and 2 saith ar 27 is		SUSAN HARMON	(DAUGHTER)				BROOKE LA			,MARYL	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ I	Removal from State			sition (Name of matory or other pla		Date			or Town, State
ţ	t. Pag rtment rtant:	-	4 □ Donation 5 □ Other (Specify,		KAI		REMATORY	D8-05	5-2008			,MARYLAND
Bal	permii Depar Impor any Ir		21. Signature of Eural Server Licens	La	2			MONS ISLA				R,MD. 21037
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused one cause on each lin	the death.							Approximate Interval Between Onset and Death
8	Physician	9	Immediate Cause (Final disease or condition			onen	al wall	hemar	lage			2d
1	/Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of):						1
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	scuted nd transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c								
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687	ificate g phys	edical		d								
Box	death certifi e aftending d for use as	Physician/Me	23b. Was decedent pregnant	23c. If yes, outcome ( 1 ☐ Live birth	2 🗌 Fetal	death 3	⊒Ectopic pregnanc	·y		1	23d. Date of o	delivery Day Year
.O.	0 0	ysici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 9□Unknown	time of de	ath 5[	Other (specify) _					
Δ.	The law requires that the de ate has been signed by the a bage 2 should be detached t		Part II. Other significant conditions of	ontributing to death bu	it not resul	ting in the u	inderlying cause gi	ven in Part I.	23e. Did	tobacco	use contribute	to the cause of death?
Records,	w requires been sign should be	ed by	auticocquite	tun the	erap	Anti Coe	gulation T	nerapy	1	] Yes 2	□ No 3□	Probably 4 Unknown
eco	e law re has bed je 2 sho	Completed	atrial fibr.	llation					24a. Wa	s an opsy formed?	24b. Were prior t death	autopsy findings available to completion of cause of
al R			aortie value	regluce	neu;			00 Di of David	1□ Yes	2 X N		es 2□ No
Vital	Physician: this certificatel director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No	Hospital: 1 X Inpatie	nt 2 ☐ E	R/Outpatie	nt 3□ DOA Ot	26. Place of Dea her: 4 ☐ Nursing H	tome 5□Re		6 □Other (S	pecify)
o c			27. Manner of Death 125 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry	28b. Time o	Wo		28d. Describe	e how inju	ry occurred	
Siol	tence eath tor:	catic	2 Accident investigation 3 Suicide 6 Could not be		At hor	mo form el	M 1 1 creet, factory, office	Yes 2 No	28f Location	(Street a	nd Number or	Rural Route Number,
Division	l or Attendate after death Director:	Certification:	4 ☐ Homicide determined	building, etc	. (Specify	)			City or T	own, Stat	e)	
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Certifying Ph (Check only one)	ysiclan: To the best of the basis of the bas	examinat	vledge, dea ion and/or i	th occurred at the nvestigation, in my	time, date and place opinion, death occ	e, and due to thurred at the tim	ne cause(s e, date ar	s) and manner nd place, and	r as stated. due to the cause(s)
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			> Val / Vel	una			Dã	17861		81	12/08	
	nost	+	30. Name and address of person who Rubort Peter	completed cause of d	eath (Item	23a) (Type	, Print)	+nnan-li	11.0	) 2	21401	
4		ate	31. Date filed (Month, Day, Year) AUG 0 6	2008 32. Redistr	ar's Signat	ture	1 .	tungely	, ,			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Carena Augnth 4. 2008 Menza Josephine 9:32 P M 4a. Facility Name (If not institution, give street and number)
Bradford Oaks Nursing Home 4b. City, Town, or Location of Death Clinton 4c. County of Death Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 25, Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Months 1 □ M 2 1 X 578 07 4023 97 1910 Switzerland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 □ Yes 2X XNo Maryland Prince George's Clinton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States 7520 Surratts Road 20735 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Xo If Yes, GiveX Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🟋 No Specify Specify: White 3XXWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Sales Person Retail Sale 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Orsola Mossi Carlo Danzi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Ines (Daughter) 875 Grace Street Apt #304, Herndon, Virginia 20170 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD Aug 11, 2008 Gate of Heaven 21. Signatur of June al Servi 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line mediate Cause (Final disease or condition resulting in death) 111 ue to (or as a consequence of) Due to for as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Ye ar Month Day 5 Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 1 ☐ Yes 2 🗹 No 2 No 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**Physician** /Medical Examiner

The law requires that the death certificate be executed

signed by the a

page 2 should

has

After this certificate

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

funeral director,

or Attending Physician:

Hospital

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Completed

Be

Medical Certification: To

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Ancidical Examinar is ust be notified at

and Mental Hygiene.

item 27 i

permit. Pages
Department of
Important: If it
any injury or o

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-trar Physician/Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending

28a. Date of Injury (Month, Day, Year) investigation

28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

(Check only one)

2 Accident

4 Homicide

3 Suicide

1🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number 045765 29d. Date signed (Month, Day, Year) 08-05-2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Michael Sidarous, 31. Date filed (Month, Day, Year) **AUG 07** 

6 Could not be

determined

11701 Livingston Road #101, Fort Washington, MD 20744 MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1530 Katherine Virginia Downes August 10 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Memorial Hospital Easton Caroline If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 □xf Director 219-07-7063 94 Jan. 14. 1914 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Caroline Preston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21182 Marsh Creek Road 21655 United States of America Funeral within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American I Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ 3 ☑ Widowed 4 ☐ Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Line Worker Poultry Processing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi Be William Doran Edna May Wooters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ss 1 and 2 sh of Health and item 27 is m A. Virginia Downes 21182 Marsh Creek Road, Preston, Maryland 21655 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages I Department of H Important; If ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or Denton Cemetery 8/14/2008 Denton, Maryland 22. Name and Address of Facility
Moore Funeral Home, P.A. 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications traticaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Approximate Interval Between Onset and Death Edema Immediate Cause (Final Mollar **Physician** disease or condition /Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence Examine the death certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. the attending physician Physician/Medical the as IF FEMALE: If yes, outcome pf pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe Yes 2 certificate Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Certification: Natural 5 Pending investigation To the Hospital or Attendil within 24 hours after dea h. To the Funeral Director A 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Hornicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 0 0 5 3 8 /5 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year) AUG 1 2 2008

Korah Pulimood,

912 Market Street, Denton, Maryland 21629 32, Registrar's Signature

17. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

eresa Ehmann		State of Maryland / Department of Certificate of			, No. 200	8 27012							
Physicia	n/	Registrar  1. Decedent's Name (First, Middle,Last)  TERESA MARIE EHMANN		2. Date of Death	Day Year	3. Time of Death 0844 hrs							
ledical Examir শ	ner		b. City, Town, or Location of Death	August 15,	4c. County of Death	00441113							
		Chester River Hospital Center	Chestertown		Kent								
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	ff Under 1 Year   If Under 24Hrs Months   Days   Hours   Min		(MM/DD/YYYY) 9. Birt Foreig								
Director		134-42-3708 1 M 2XF 57 Yrs.	Months Days Hours Will	June :	21 195 Co	untry) NY							
any	}	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits							
<b>*</b>	٦	MD Kent Kennedyv	ille			1 Yes 2 No							
Maryland 28a-f show d at once.	Director	10e. Street and Number	10f. Zip Code		g. Citizen of What Cour	ntry?							
th the 23a or		12564 Augustine Herman Hwy.	21645		U.S.A.	can Indian, Black,							
eath wi	Funeral	1 Never Married 2 Married Armed Forces? If Ye	s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto		White, etc.	carrindan, black,							
after de	by Ft	Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 X No specify:			ite							
hours nature	ed	duning mo	's Usual Occupation (Give kind of ost of working life. DO NOT use ret		16b. Kind of Business/l	ndustry							
336 thin 72 ne. than tedical	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  1 2 Nail	Technician		Beauty S	alon							
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica		17. Father's Name (First, Middle, Last)	18.Mother's Name										
2121 ould be fi Mental I marked ic event,	o Be	William John Friedel  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing	Address (Street and Number or		rie Gugel	Zin Code)							
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Menial Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	۴	Harold Miller (companion) 1256											
re, Nand Land Health		20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State crematory or oth	Date	20c. Location - City or	Town, State								
imore Pages 1: nent of H annt: If it or other t		4 Denation 5 Other Specify: Shrewsh	oury Cem. 8/	19/08		ille, MD.							
Baltimore, MD 2121. permit. Pages 1 and 2 should be fil Department of Health and Mental I. Important: If item 27 is marked injury or other traumatic event,		21. Signal and of Funeral Survice Europsee 22, N	Home o	f Stephen	L Schaech								
Physician	-	M00510 11	IENA, MD.	21635 Approximate Interval Between Onset and									
/Medical xaminer		failure. Idst only one cause on each line.  Immediate Cause (Final disease a. Coronary Artery Thrombosis											
Kallillei		or condition resulting in death)  Due to (or as a consequence of):  b. Hypertensive Atherosclerotic Cardi	ovascular Disease										
	ē	if any, leading to immediate Due to (or as a consequence of):	01450414, <b>2</b> 166450										
	aminer	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (c. Due to (or as a consequence of):											
cecuted and transit	al Exa	d.		<del></del>									
o, o, e be exe e be exe ysician purial -	edical	UNPENDED			T								
ox 6876(eath certificate attending phy for use as the h	In/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fe	tal death 3 Ectopic pregn	ancy	23d. Date of deliver Month	y Day Year :							
Box 6876 death certificate the attending phy of for use as the	Physician/M		her (Specify)										
D. B.	Phy	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?							
P.O. ires that to signed by I be detac	d by			1 Yes	2 🗸 No 3 Pro	bably 4 Unknown							
ords w requi	olete			24a. Was a autop:	sy prior to	utopsy findings available completion of cause of							
Records,  The law requir ficate has been si	Completed			perfor 1 <b>Y</b> Yes		es 2 No							
ital Recionant The scertificate rector, page	å	25. Was case referred to medical examiner? Hospital: Inpatient 2 ✔ ER/Outpatient	26.Place of Death (Check 3 DOA Other Nurs		Residence 6 Othe	or.							
25. Was case referred to medical examiner?  1  Yes 2 No  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  28d. Describe how injury occurred													
ion (tendin eath.	ation	1 V Natural 5 Pending 2 Accident Investigation	1 Yes 2 No										
Division pital or Attendio ours after death. eral Director: filled in by the fu	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street	et, factory, office building, etc.	28f. Location (S or Town, S		ural Route Number, City							
Ospita lospita l hours uneral		4 Homicide determined (Specify)  29a. Certifier Check pally  Certifying Physician: To the best of my knowledge, death occur	red at the time, date and place, an	d due to the caus	e(s) and manner as sta	ted							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transi	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.											
F 3 F 8	Me	29b. Signature and fittle of certifier	29c. License number		29d. Date signed (Mo								
			O.C.M.E.		August 16, 2008	5							
OCME		Name and address of person who completed cause of death (Item 23a)     Mary G. Ripple MD. Deputy Chief Medical Examiner 11:	1 Penn Street, Baltimore,	MD 21201									
St	ate	31. Date filed (Month, Day, Year). 32 Registrar's Signature	N.										
Regist		AUG 2 1 2008											

				k Indelible Ink.		-	_	
		State State	of Maryland /	Department of H			200	27012
		Registrar		Certificate of		Reg. No	<u>2008</u>	2/013
Physici /Medic		Decedent's Name (First, Middle, Last)     Bayard	Delancy Eng			400021 1	16 480X	3. Time of Death
Examin	_	4a. Facility Name (If not institution, give street and	PARE SYSTI	4b. City, Town, o	Y POINT	40	c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 1 № M 2 □	7. Age (In yrs. last bi	Yrs. If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	3. Date of Birth (Month, Day, Year JAN 23, 19	9. Birth Cou Ma	pplace (State or Foreign intry) ryland
yland low at		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tov	vn or Location				10d. Inside City Limits
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	Maryland Cecil	E1kt			10~ 0	itizen of What Co	1 ☐ Yes 2 🕅 No
with t	I Dir	10e. Street and Number		10f. Zip Code 21921			United S	
ms 23	Funeral	13 Sunnybrook Drive  11. Marital Status  12. Was I	Decedent Ever in U.S.	13. Was Decedent of H	lispanic Origin? (Spec		14. Race - Amer Black, White	ican Indian,
after or ite		It 47es	d Forces? World es 2 No War II	1 ☐ Yes 2 ☑ No	Specify:	ioan, oto.)	Specific	
hours tural"; al Exz	ed by	3 Widowed 4 ☐ Divorced Year of the State of	or Datos.	a. Decedent's Usual Occur	pation	16b.	Wh Kind of Business/l	ite
hin 72 e. In "na Medic	Completed	(Specify only highest grade complete	ed) ge (1-4or 5+)	(Give kind of work done life. DO NOT use retired Heavy Equip	during most of working d) ment Opera	7 1		
ed with	Com	10	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Instructor				g Engineers
intal H ed oth	Be	17. Father's Name (First, Middle, Last)  Albert H. England			18. Mother's Name			
should nd Me mark umatk	은	19a. Informant's Name/Relationship (Type. Print)	19	b. Mailing Address (Street				(ip Code)
and 2 salth a 27 is er trai		William E. England/Son		13 Sunnybrool	k Drive, E			
ges 1 t of He If Item or oth		20a. Method of Disposition 1 X Buria! 2 □ Cremation 3 □ Removal for	rom State cemet	of Disposition (Name of tery, crematory or other pla	<sup>ce)</sup>  August	21,	Location - City or	
it. Pa trtmen rtant: njury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Old Bo	ohemia Cemete	ery 2008	Wa	arwick, N	MD
permi Depar Impor any tr		21. digitality of 1 different deliving Electrises	0.	Hicks Home 103 W. Sto	e for Funer	cals, P.A. Pet. Elkto	on. MD 2	21921
( T) ( T)		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause	nat caused the death. Do					Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	VA STAGE C	HAONIE OBSTR	urtive pulm	IONARY DI	SEASE	Onset and Death
/Medical Examiner		resulting in death)	e to (or as a consequence	e of):				
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e to (or as a consequence	e of):				
cuted nd ransit	Examiner	that initiated events c					b	1
icate be executed physician and s the burial-transit		resulting in death) Last Du	e to (or as a consequence	e of):				
physics the t	dice	d						
eath certific attending pl for use as t	Physician/Medical	23b. Was decedent pregnant	, outcome pf pregnancy ive birth 2 ☐ Fetal dea		;y		23d. Date of de Month	livery Day Year
at the dea by the at stached fo	hysici	1 TV00 2 TN0 4 T	regnant at time of death	5 Other (specify)				
ires that signed a be de	þ	Part II. Other significant conditions contributing	to death but not resulting	in the underlying cause gi	ven in Part I.			o the cause of death?  robably 4 Munknown
w require been si should b	letec	DIAGETES MEXITU	S TYPE II			24a. Was an	24b. Were a	utopsy findings available
The lav	Completed	and the ball of the total				autopsy performed 1 Yes 2 ■	? death?	completion of cause of 2 □ No
stctan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?  Hospital:	w/	lo	26. Place of Death	(Check only one)		
Physic rthis cral dir	<u>유</u>	27. Manner of Death 28a. I	Date of Injury 28b	Dutpatient 3 DOA  Time of lnjury  28c. Inju		ne 5 Residence		ecify)
nding tth. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)		ork? ]Yes 2 □No			
or Atter fter dea Director	Certification:	3 Suicide 6 Could not be determined 28e. I	Place of injury - At home, building, etc. (Specify)	farm, street, factory, office	2	28f. Location (Street City or Town, St		ural Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: T						
the Hin 24 the Fi	Medical	one) and	manner stated.		se number		Date signed (Mon	
To To	-	29b. Signature and title of certifier	ashmi	MD D2	4648	<u> </u>		-2008
		30Name and address of person who completed	cause of death (Item 23a	a) (Type, Print) HEALTH EARE	SYSTEM	NERRY POIL		21902
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	THE NEW YORK		THE POST OF THE	) 124	VI
Regist		THE ST PROS	A STATE OF THE STA					

Dr.

State of Maryland / Department of Health and Mental Hygiene Reg. No 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last)  $31^{\text{Day}}$ **Physician** July 2008 Helen Joan Eze11 10:55A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Laurel Regional Hospital Laurel Prince Georges If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 😾 F 578-56-3034 Director Sept.24,1942 Maryland | Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No Director MD Prince Georges Laure1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or Items 23a or edical Examiner must be 13184 Larchdale Rd. Apt. 6 20784 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2★ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐xNo Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Benefit Specialist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irvin Lacy Doris Bond Pages 1 and 2 should nent of Health and Men 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Davenport/Mother 5123 12th St. N.E. Washington, D.C.20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once, Washington National Aug.8,2008 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Latney's Funeral Home, Inc. 278 3831 Georgia Ave. N.W. Wash., D.C. 20011 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Fungemia / Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Urinary Tract Infection Sequentially list conditions, it any beding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse juence of): Examine be executed sician and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1₺ Yes 2☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Acute Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed Aspiration Pneumonia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Coronary Artery Disease certificate 1□ Yes 2 No r this certificaral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Hospital or Attending 1 XNatural 5 ☐ Pending investigation Within 24 hours arter community to the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064986 7/31/2008 MB 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chike Onwuka, MD 10724 Little Patuxent Parkway Suite 200 Columbia, Md 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

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AUG

2008

Baltimore, Maryland 21215-0036

| 記々 23舟( 舟) かん かん ひん ひん ひん ひん ひん ひん ひん ひん の Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Day **Physician** 1:30 P AUG. 2008 **EDNA** EUBANK 1,\_ /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CLINTON PRINCE GEORGES FUTURECARE PINEVIEW NURSING HOME If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2 💢 F 92 FEB. 10,1916 JAMAICA Director 215-49-5792 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1

Yes 2□No Director PRINCE GEORGES CLINTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code JAMAICA 10205 THRIFT RD. 20735 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐Yes 2 No Yes, Give 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **EUDORA** ROWE CLEMENT **EUBANK** ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10205 THRIFT RD., CLINTON, MD. 20735 GLORIA ROBINSON/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place MAMBY PARK BAPTIST CHURCH CEMETERY Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If It
any injury or o
once. 1 ☐XBurial 2 ☐ Cremation 3 ☐Xemoval from State 4 Donation 5 Other (Specify) 8-16-2008 KINGSTON, JAMAICA 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE, RIVERDALE, MD. 20737 21. Signature of Funeral Service Alcensee M00091 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ovascular n sease **Physician** resulting in death) /Medical Examiner Se\_uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the detached 9 Unknow been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မှ this 28b. Time of 27. Manner of Death 1 Natural 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: After (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or Attendition within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)
AUG 0 7

32 Registrar's Signature

30. Name and address of person who comple ed cause of death (Item 23a) (Type, Print)

2008



29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	S	tate of N	ıaryıan	•		nt of H te of L			entai my	rgieni Reg. No	ZUU	38	270	)   6
	Dhyelei	,te	1. Decedent's Name (First, Mi	ddle, Last)							1	2. Date of De	eath Da	av	Year	3. Time of	Death
	Physici /Medic		Osborne Holm									July	2	ó <b>,</b> 2	800	3:54	. A™
	Examin	er	4a. Facility Name (If not institu			)			, Town, or		of Death		40	County o		1.	
4			8904 Mountair 5. Social Security Number	6. Sex		an (In ven	In at hirthdays		ederi er 1 Year		24 Hrs.	B. Date of Bi	rth	Fred	0 D: II	1 (0)	or Foreign
	Funeral Director		214-10-3087	1 M M		92	last birthday) Yrs.	Months		Hours	Min. A	pr. 10	ay, Ye <i>ar</i>	916	Coul	Mary	Land
	ryland show	L	Usual Residence of Decedent  10a. State 10b. Cou	nty		10c. Cit	y, Town or Lo	cation							1	I 0d. Inside Ci	
	Ba-f s	Director		derick		Fı	rederic										2 <u>2</u> NO
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	s 23	eral	8904 Mountainl		ircle Was Deceden	t Ever in 11	6 123		21702		rigin? (Cnor	ify Vos or N		Jnite		ates can Indian,	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, It. Wedical Eventing 1.	by Funeral	11. Marital Status 1 ☐ Never Married 2점 N 3 ☐ Widowed 4 ☐ Divord	larried	was beceden Armed Forces 1 X Yes 2 ☐ If Yes, Give Year or Dates	? ] No			ecify Cuba 2₩ No	Specify		ify Yes or Nican, etc.)		Black	k, White,	etc.	
21215-0036	vithin 72 ho ane. <b>:han "natu</b> .walifal	Completed	15. Dece (Specify only hig Elementary/Secondary (0-1:		on <i>mpleted)</i> College (1-4or	5+)	life.	kind of w DO NOT	ork done d use retired	during mo:	st of working	3		Kind of Bu		vernme	nt
2	iled w Hygie ther t		17. Father's Name (First, Midd	lle Last)				Prin	ting	18. Moth	er's Name	(First, Middle				vernne	11.6
Maryland	d be f ed or	Be c	Lewis Fraley		Sr							ay Chr			-,		
ΙŽ	should nd Me mark mati	은	19a. Informant's Name/Relation		•		19b. Mailir	ng Addre	ss (Street			Route Numi		or Town,	State, Zij	Code)	
Ž	1 and 2: Health a tem 27 Is		Kathryn L. Fag	an, Wi	fe		8904	Moun	tainb	erry	Circ	le, Fr	edei	cick,	MD	21702	
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If Item 27 Is any injury or other tra <u>900ce</u> .		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other	on 3 □ Rem	oval from State	*	Place of Disponentery, cremetery, cremetery			e)	July 2					own, State Maryla	d
Balti	permit. P Departm Importar any inju		21. Sig. ature of Funeral Serv		0 >		22 K	Name eene	and Addres	ss of Facil	rd P.	A. Fun	eral	L Hom	e		
			23a Part L Enter the disease	or complicati	ons that cause									erick	, MD	21701 Approximat Interval Bet	
	Dhysisian	0.0	23a. Part 1, Enter the disease shock, or heart failure. I Immediate Cause (Final	ist only one c								,	,			Onset and	Death
	Physician /Medical		disease or condition resulting in death)	a	Car Due to (or a		a of the	he E	sopha	us						1 Yea	ır
7	Examiner			b. —			,,										
	₽ #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	J "-	Due to (or a	s a conseq	uence of):										
	ecute and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	-												
68760,	tificate be executed g physician and as the burial-transit		resulting in death) Last		Due to (or a	s a conseq	luence of):										
87	physi the b	edical		d													
O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		If yes, outcom 1  Live birth 4  Pregnant 9  Unknown	2 Feta	al death 3	⊒Ectopic ⊒Other (	pregnanc specify) _	у				23d. Dat Mo	e of deliv		Year
σ.	that the		Part II. Other significant con-	litions contrib	uting to death	but not res	ulting in the u	nderlying	cause give	en in Part	I.	23e. Did	tobacco	use contr	ribute to t	the cause of	death?
rds	quires an sign	ed by										1 🗆	Yes	2 <b>₽</b> No	3 ☐ Pro	bably 4□	Unknown
Records,	'he law requir te has been s age 2 should l	Completed										per	opsy formed?	r c	orior to co death?	opsy findings ompletion of o	available cause of
Vital	slclan: The certificate h rector, page	Be C	25. Was case referred to med	ical						26. Plac	e of Death	1 □ Yes (Check only		10	I ∐ Yes	2 🗆 No	
f V	nyslc  nis ce direc	ToB	examiner? 1 ☐ Yes 2 <b>X</b> No	Hosp	oital: 1 ☐ Inpa	tient 2	ER/Outpatie	nt 3 🗆 I	OCA Oth	er: 4 🗆 N	lursing Hom	ne 5⊠Res	sidence	6 □Oth	er <i>(Spec</i>	ify)	
on of	oding Pr th. : After the funeral	tion: 1	27. Manner of Death 1 Natural 5 ☐ Per 2 ☐ Accident inve	ding estigation	28a. Date of Ir (Month, L	jury Day, Year)	28b. Time o Injury	f M	28c. Injur Worl 1 🗆	yat k? Yes 2[	i	8d. Describe	how inj	ury occurr	ed	_	
Division	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director, to the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Co	uld not be ermined	28e. Place of I building,	njury - At h etc. (Speci	ome, farm, str fy)	eet, facto	ory, office		2	8f. Location City or To	(Street a own, Sta	and Numb ite)	er or Rui	ral Route Nur	mber,
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	To the within To the Somple	Me	29b. Signature and title of cor	ffler /				2	9c. Licens	e number			29d. E	ate signed	d (Month	, Day, Year)	
			•	lun	Lan				D	471	01			8/13	3/0	8	
			30. Name and address of pers	son who comp	leted cause of	death (Iter	m 23a) (Type,	Print)							-		
			WING TAY	u, m	D	195	Thoms	as J	ohus	ons	Drive,	Free	den	ik,	MI	0 217	02
	Sta Registi		31. Date filed (Month, Day, Ye		32. Regi	trar's Signa	ature	Som	K		,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2008 4:40 P M August Donna Marlene Fischer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Williamsport 11337\_Sword Rd. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Nov. 12, 1941 9. Birthplace (State or Foreign Country) Mary land 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F 66 Director 216-38-0840
Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the <u>Medical Examiner must be notified at</u> 1 ☐ Yes XXNo Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11337 Sword Rd. 21795 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes XXNo
If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 Specify: 3 Widowed 4 □ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dietician Medical 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Claudis Preston Turner Charlotte Marie Scott ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21795 Joni K. White - Daughter 13 S. Vermont St. Williamsport, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Dopation 5 Other Specify Greenlawn Mem. Park | Aug.13,2008 Williamsport, Maryland 21. Signature of Funeral Service Vicens OSBOT ne Attenderativ Home, P.A. 425\_S.\_Conococheague St. Williamsport, MD 21795 Pm1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician o munth /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or light) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and burial-trar Due to (or as a consequence of): physician Box 68760 Physician/Medical the as attending IF FEMALE: asn 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month 5 ☐ Other (specify) P.0. the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, by 1₽Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 1 Watural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I Director: After to d in by the funera Medical Certification: or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours after To the Funeral Dire Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 41667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) McCorneck

31. Date filed (Month, Day, Year) AUG 1 2 2008 32. Registrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene 008 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Willard L. 2 2008 5:36 a. August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner University of Maryland Hospital Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1**X** M 2□ F Director 72 June 14,1936 Frostburg, MD220-32-3887 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23e or 28e-f show treumatic event, Its May cal Examiner must be multilled at 1 N Yes 2 No Directo Mineral Keyser 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 710 Virginia Street 26726 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. Be Completed by 3 Widowed 4 Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Millwright Paper Mill 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fit and Mental Fit is marked of Lindley O. Green Myrtle R. Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . 1 and 2 s' if Health ar ittem 27 ir Gretchen H. Green/Wife 710 Virginia Street Keyser, WV other t 20b. Place of Disposition (Name of cemetery, crematory or other place)
Potomac Memorial Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 tment of I rtent: If it 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 6 ö permit. Page Department of Importent: If any injury or once. 1 □ Burnar 2 □ □ Greater (Specify) Entombment Gardens Mausoleum 2008 Keyser, WV 21. Signature of Funeral Service License 22. Name and Address of Facility Smith Funeral Home Houan 85 S. Main Street Keyser, WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician AMLdisease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Kijury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown None Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 certificate 2 No 1 Tes 2**∑** № Physicien: ral director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 X Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2X No Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After or Attending Injury 1 XNatural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide filled within 24 hours a 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie, 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. greene St., Baltimore, MD Angela D. Frates, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 2008 AUG 2 Registrar

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within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di Medical Certification: To		2 Accident 3 Suicide 4 Homicide	6 Could n determi	ot be	e. Place of inj building, et	ury - At hor tc. (Specify,						28f. Location (S City or Tov			or Rura	al Route Numb	er,
or the Funeral ompletely filled Medical C	2	29a. Certifier (Check only one)		Examiner: 0		of examinati						and due to the red at the time,					
To the complet	2	9b. Signature and	title of certifier	ma	3			290	. License	e number			29d. Date	e signed (	(Month,	Day, Year)	
land		•	13	111)	no				İ	7259.	33			8.5	50	8	
de	3	0. Name and add	ess of person	who complete	ed cause of o	death (Item	23a) (Type,	Print)	ys L	dre,	Ea.	ston, p	10	216	01		
State Registrar	3	1. Date filed (Mon	th, Day, Year)	2008	32. Jegistr	rar's Signat	ure	horde				ston, f	•				

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

			1 _ State	State of Marylan		artment of F		Mental		201	08	27020
			Registrar  1. Decedent's Name (First, Middle, Last)				Dealli	2. Date	Reg. No f Death	oL 0		3. Time of Death
Н	Physici /Medic		MARY	GOLDSTE	IN			Mont		24 S	Year 2008	9:42 P M
maria	Examin		4a. Facility Name (If not institution, give str		10.		r Location of Dea	ath	40	c. County		
			5. Social Security Number 6. Sex	LE GARDEN 7. Age (In yrs. 1		7	KVILLE If Under 24 Hr	s. 8. Date	of Rirth	190	9 Rithol	ace (State or Foreign
	Funeral Director			1 2XF 9	Yrs.	Months Days	Hours Mir		th, Day, Year	716	Count	NY Y
:	pu »		Usual Residence of Decedent	140-00		J			<del>/                                    </del>		T40	od Innida City Limita
	f shov	ō	10a. State 10b. County		7, Town or Lo						10	)d. Inside City Limits 1 <b>X</b> Yes 2 □ No
	the N	Director	MD MONTGO	PLENT	COCKV	10f. Zip Code			10g. C	Ditizen of V	Vhat Count	ry?
	h with		14401 TRNILLE	GARDEN GR	CLE	20	850		U.	S.A.		
	r deat	Funeral	11. Marital Status	. Was Decedent Ever in U.: Armed Forces?	3. 13.	Was Decedent of H	lispanic Origin? ( an, Mexican, Pue	Specify Yes rto Rican, et		14. Race	e - America k, White, e	
36	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Exaction routs be redified at	by F	1 ☐ Never Married 2 ☐ Married 3 M Widowed 4 ☐ Divorced	1	1	1 □Yes 2 No	Specify:			Specify	WH	ITE
9	2 hou	ted	15. Decedent's Educa	tion		dent's Usual Occup			16b.	Kind of Bu	siness/Ind	
2	ithin 7 ne. nan "n	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire	during most of wo d)	orking			_	
2	iled w Hygiei ther th	S	17. Father's Name (First, Middle, Last)		Secre	etary	18. Mother's Na	ame (First M		pital		
Maryland 21215-0036	ed ital	To Be	Dominick Angiello				Carmil			! Aqu		
ary	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic	-	19a. Informant's Name/Relationship (Type	. Print)	19b. Maili	ng Address (Street	and Number or F	Rural Route I				Code)
χ. Σ			Michael Goldstein		1	le Drive						
201	ages 1 nt of H : If Ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Rer	noval from State		osition (Name of matory or other plac		Date	Hast	tings	City or Tov	wn, State Hudson <b>,</b>
altimore,	nit. Partme artme ortani Injury		4☐Donation 5☐Other (Specify)  21. Signature of Funeral Service Licensee		Норе	2. Name and Addre		8/2008		York		
ñ	permit. Pages 1 and Department of Healt Important: If Item 2' any Injury or other once.				1 a	2. Name and Addre .nzansky-( l 70 Rockv	Goldberg ille Pik	Memor e Roc	ial Cl ckvill	napel e.MI	s, Ir 208	ic. 52
			23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death								Approximate Interval Between
27-2	Physician		Immediate Cause (Final disease or condition resulting in death)	CARDIOPU	LMON	ary Aa	REST					Onset and Death
r	/Medical Examiner		resulting in death)	Due to (or as a consequ ATTENU SC	,	L Hen	o- D	SEMSE				
		Jer	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ		, (101)	101	35135				
	ecuted ind transit	Examine	that initiated events c.	RHEUNATO		ARTHA	ns.					
8760,	death certificate be executed e attending physician and of for use as the burial-transit	E E	resulting in death) Last	Due to (or as a consequ	ience of):							
687	ificate g phys	edical	d. ,									
Box	eath certific attending p for use as	M/ue	230. Was decedent pregnant	lf yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		☐ Ectopic pregnanc	°V				e of delive	
о П	ne dea the att hed fo	Physician/Me	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4 Pregnant at time of do		Other (specify)	,,			Мо	nth	Day Year
σ.	w requires that the de s been signed by the should be detached		Part II. Other significant conditions contri	buting to death but not resu	Iting in the u	nderlying cause giv	en in Part I.	23e.	Did tobacco	use cont	ribute to the	e cause of death?
Records,	quires in sign uld be	d by							1 ☐ Yes	2 <b>1</b> No	3 ☐ Proba	ably 4 ☐ Unknown
ဝ္ပ	law redias bee	Completed						24a.	Was an	24b. \	Were autop	osy findings available inpletion of cause of
	The ate h	E						1 📗	autopsy performed? Yes 2	1	death?	2 No
Vital	Ictan: certific ector,	Be	25. Was case referred to medical examiner?	spital:		Louis	26. Place of De					
ō	Phys er this eral dii	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatient 2 ☐ ☐ 28a. Date of Injury	ER/Outpatier 28b. Time o		4 LI Nursing		Residence			9
<u>0</u>	inding ath. r: Afte	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	f 28c. Inju Wor M 1 🗀	ḱ?  Yes 2∐No			,		
Division of	r Atte ter de: irecto irecto	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Local City	tion (Street a	and Numb	er or Rurai	l Route Number,
	pital c	O	29a. Certifier 1 Certifying Physic	ian: To the best of my know	uladaa daat	h accurred at the ti	me, data and pla	oo and due	to the source	(a) and m	nanar an at	totad
	To the Hospital or Attending Physician: In the Funeral Director: After this certifica completely filled in by the funeral director,	edical		r: On the basis of examinat and manner stated.								
		Me	29b. Signature and title of pertifier			29c. Licens			29d. D	ate signer	d (Month, L	Day, Year)
	7		1 ( ). /			10:	38512			7/2	5/08	
			30. Name and address of person who com	leted cause of death (Item	23a) (Type,		LIVE R	10	2	11-	MN	20250
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	- C	1-41	)	WERV!	L C C	10	00000
	Registra	ar	AUG 0 7 2008	Bour St	600	de la company de						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 08 Month **Physician** Vellie L Grant 8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Rehab and Nursing Burtonsville Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🔯 F Yrs 78 Director 3/4/1930 NC 245-42-1612 Usual Residence of Decedent the Marviand 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notifled at Y Yes 2 No Director Montgomery Silver Spring MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with: Department of Health and Mental Hygiene. Inportant: If them 271s marked other than "natural", or items 23a or any Injury or other traumatic event. the Marikal Eventors. USA 14. Race - American Indian, 15107 Interlachen Drive #405 Funeral 20906 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2**X** No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black by 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Guidance Counselor DC Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Martha Pitt John C. Laws 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7907 Thrush Meadow Pl Severn, MD April Cephus/Niece 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 8/8/2008 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 22. Name and Address of Facility Marshall's Funeral Home on Funeral Service Licensee 21. Signatury 4217 Ninth Street, NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner imhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): the attending physician by Physician/Medical as the IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9□Unknown 9 I Unknowe signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐No 24a. Was an has autopsy perform this certificate 2 No or Attending Physician: after death.

Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4⊠Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records, P.O. Box 68760 To the Hospital or within 24 hours at To the Funeral D

> State Registrar

29b. Signature and title of certifier

Sunika Bhogavilli 31. Date filed (Month, Day, Year)

AUG 07

29c. License number

9801 Georgia Avenu #1-17, Silvers Pring

D0054566

29d. Date signed (Month, Day, Year)

and manner stated

32. Pojistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

chr. stopher Godsey Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-05920 2008 27022 State of Maryland / Department of Health and Mental Hygiene **UNK UNK** 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Physician/ . Decedent's Name (First, Middle Last) 1525 hrs August 2, 2008 Medical Examiner ounty of Death 4b. City, Town, or Location of Death if not institution, give street and number Baltimore 700 block W. Franklin Street 9. Birthplace (State of If Under 24Hrs 8. Date of Birth (MM/DD/) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** oreign Min Hours Months Days Country) Director 220.80.334 1X M 2 Yrs Usual Residence of Deceden 10d. Inside City Limits Jown or Location 10c. City, 10a. State 10b. County any Yes 2 No 23a or 28a-f show notified at once. with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Numbe Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items White, etc. Armed Forces? 1 Never Married 2 Married permit. Pages I and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene.
Important: If item 27 is marked—injury or other— 1 Yes 2. No specify: Specify: U Yes, Give Yea 4 Divorce Widowed à 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) (First, Middle, Maide 17 Father's Name (First, Middle, Last Rural Route Number, City or Town, State, Zip Code) (Street and Numb 20b. Place of Disposition (Name of cemetery 20a. Method of Dispos crematory or other place) 2 X Cremation 3 Removal from Stat Burial Donation 5 Other Specify sons Funeral Chapel 21. Signature of Funeral Service Licenses M01080 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator Physician Between Onset and failure. List only one cause on each line Death Medical Cocine intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ned by the attending physician and detached for use as the burial - transit Physician/Medical AMENDED 23a,27,28a-f, per ME g883 9/11/08 TT X UNPENDED The law requires that the death certificate be Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. O 1 Yes 2 V No 3 Probably 4 Unknown ò ۵ Completed Records. 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has brector, page 2 sh death? performed? 1 🗸 Yes ✓ Yes 2 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death 25. Was case referred to medical Division of Vital Be Other<sub>4</sub> examiner? Nursing Home 5 Residence 6 Other: Scene Hospital: DOA FR/Outpatient 3 Inpatient 2 this ٩ 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28h Time of Injury After 27. Manner of Death Certification: Yes 2 X No Natural Pending Director: Fnd 8/2/08Fnd 3:15 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number City or Town, State) 700 Blk. W. Franklin St. Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide woods determined (Specify) To the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier August 3, 2008

Registra

**ORIGINAL** 

gistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a)

2008

Margarita Korell MD.

31. Date filed (Month Day)

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

			For State Registrar	State	of Maryla		artment of F			giene Reg. No. 20	0.8	27023
			Decedent's Name (First, Middle	e, Last)					2. Date of De Month		Year	3. Time of Death
	Physicia /Medic		William E	dward	Hill,	Sr.			August	14 2	2008	3:05P <sup>M</sup>
and the same	Examin		4a. Facility Name (If not institutio				4b. City, Town, o		eath	4c. County		
, s - 1			Carroll Hospi 5. Social Security Number	ce Dove l		s. last birthday)	Westn If Under 1 Year	ninster I If Under 24 H	rs. 8. Date of Bir	th	9. Birthp	lace (State or Foreign
	Funeral Director		215-32-4232	1 M 2□ F	77	Yrs.	Months Days	Hours M	in. (Month, Da	ay, Year)	Coun	nsylvania
	ס		Usual Residence of Decedent								1	0d. Inside City Limits
	arylan show		10a. State 10b. County		10c. C	City, Town or Lo					'	1 X Yes 2 □ No
	he M	Director	Maryland Car	roll			Union	Bridge		10g. Citizen of	What Cour	ntry?
	a or		11 Benedum S	it.				1791		U.S.	.Α.	
	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show ent, the Madical Evenina must be notified at	Funeral	11. Marital Status		cedent Ever in	U.S. 13.	Was Decedent of H If Yes, specify Cuba		(Specify Yes or No	)- 14. Ra	ce - Americ	
9	after or ite		1 ☐ Never Married 2 【※ Mar	ried 1 XYes	2 □ No		1 ☐ Yes 2 ☐XNo	Specify:	icito (tiodii, oto.)		<sup>y</sup> Blac	
3	ural",	d by	3 Widowed 4 Divorced	Year or	Dates:1 952		dent's Usual Occup	nation		16b. Kind of B		
2	in 72 l	Completed	(Specify only highe	nt's Education est grade completed		l (Give	kind of work done  DO NOT use retire	during most of v	working			,
7 7	d withi	E O	Elementary/Secondary (0-12)	Conege	(1-4or 5+)		truck dri				struc	tion
and	be filed ntal Hyg ed othe event,	Be	17. Father's Name (First, Middle						Name (First, Middle		me)	
Z Z	should band Ment s marked	၉	Hugh Duppi						lizabeth		0.4.70	- 0-4-)
Mar	12sh hand 7ism traum		19a. Informant's Name/Relation				ing Address (Street		eytown, N	_		o Code)
as î	s 1 and 2 should be filed within 72 hours after death with the Marylan of health and Mental Hygiene with the marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modeal Eventine must be notified at	-	Juanita Hill/ 20a. Method of Disposition	baugnter	20b		Taney Dr. osition (Name of matory or other pla		Date	20c. Location		own, State
	Pages nent of I ant: If ite		1 ☐ <b>X</b> Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3		n State		matory or other pla 5 Cemeter		20/2008	New Wi	ndsor	- MD
aitimoi	in in it		21. Signature of Funeral Service		1/2/		2. Name and Addre		Hartzler			
מ	Dep Imp		Langue 7	(310)	HULL		6 E. Broa		Union Br		D 217	
			23a. 1. Enter the disease, c shock, or heart failure. Lis	it only one cause or	n each line.			ng, such as car	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
-	Physician		Immediate Cause (Final disease or condition resulting in death)	He	ad and	Neck Ca	ancer					Onset and Death 3 months
	/Medical Examiner		resulting in death)		o (or as a conso ophagea		or.					3 months
		er	Sequentially list conditions, if any, boong to in modal cause. Enter Underlying Cause (Disease or injury	b	o (or as a cons		-1					J 111011 C110
	cuted id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	G.								
Ď,	cate be executed oblysician and the burial-transit		resulting in death) Last	Due t	o (or as a cons	equence of):						
8/PU	cate b	dical		d							-	
×	leath certificate attending phys for use as the	Physician/Med	IF FEMALE:	23c. If yes, o	outcome of preg	inancy				23d. D	ate of deliv	verv
gox	eath atter for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Liv 4 ☐ Pre	e birth 2 1 Fe egnant at time o	etal death 3	☐ Ectopic pregnan ☐ Other (specify) _	су			onth	Day Year
л. Э	t the c by the achec	hysi	9 Unknown	9 □ Un	known							
	w requires that the dispersion is been signed by the should be detached	by P	Part II. Other significant condit				underlying cause gi	ven in Part I.				the cause of death? loably 4 □ Unknowr
<u>0</u>	een s	ted							_	Yes 2 No	3 🗀	
Records,	has has	Completed	Coronary Ar	tery Dise	ase				— 24a. Wa auto per	s an 24b opsy formed?	prior to co death?	opsy findings available ompletion of cause of
Vital	ician: The certificate h ector, page		OF Management to modic	ol T				OC Place of	1 □ Yes	2 No	1 □ Yes	2 No
	rsicia s certi lirecto	o Be	25. Was case referred to medic examiner?  1 ☐ Yes 2 ☐ No	Hoenital:	☐ Inpatient 2	☐ ER/Outpatie	ent 3 DOA Ot	har:	Death (Check only ng Home 5 ☐ Re		ther (Spec	ity) Hispice
10	Attending Physician: sr death. ector: After this certifica by the funeral director, p	n: T	27. Manner of Death	28a. Da	te of Injury	28b. Time	of 28c. Inju			how injury occu		7 007.00
Ö	endin ath. or: Aff	atio	Z LI Accident	tigation	onin, bay, roar,	,,,		]Yes 2 □ No				
DIVISION	or Atte	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined   200. Pla	ice of Injury - At ilding, etc. <i>(Sp</i> e	t home, farm, s ecify)	treet, factory, office		28f. Location City or To	(Street and Nun own, State)	nber or Rui	rai Route Number,
	pital o		29a. Certifier	ring Physician:	the hast of my	knowledge, dea	ath occurred at the	time, date and r	place, and due to the	ne cause(s) and	manner as	stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medica	al Examiner: On the	e basis of exam anner stated.	inction and/or	investigation, in my	opinion, death	occurred at the time	e, date and place	e, and due	to the cause(s)
	To the To the compl	Me	29b. Signature and title of certif	ier	1_		29g. Licen	nse number		29d. Date sign	ned (Month	, Day, Year)
			•		1		1 h	530	2/	8/13	100	7
			30. Name and address of person	n who completed co	ayse of death (I	tem 23a) (Type	e, Print)	~Ch ~ ~ ~ ~ ~ ~ ~	~ . 20 200	<u></u>		
			31. Pate filed (Month, Daylea	( 500 C	Registrar's Sign		Strootlike	DINICO	a Import	<i>)</i>		
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Hospital or Attending Physician: e Funeral I

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111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registra

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

Assistant Medical Examiner

Homicide 29a. Certifier (Check only

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

or Town, State)

29d. Date signed (Month, Day, Year)

August 11, 2008

To the Hospital o within 24 hours aff To the Funerel Di completely filled in 2

Medical

31. Date filed (Month, Day, Year) State 07 Registrar

LEENA RAO

29b. Signature and title of certifier

Leenak

00

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier



MD

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D67788

29d. Date signed (Month, Day, Year)

			For	State of	Maryland					and Me		_	000	27027
			State Registrar	1 -0	<del></del>	Cer	tificate	e or L	veatn ———	12	. Date of Deat	eg. No.Z	008	3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle		rrroon	ק					Month AUGUS!	Day	2008	2:40 PM
	/Medic		AGNES ES  4a. Facility Name (If not institution		LLIFFE	<u>,</u>	4b. City.	Town, or	Location o		AUGUD.		ounty of Death	
	Examin	er	Bethesda Reha	-		enter	•	Bet	hesd	a		MO	NTGOM	ERY
3	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. las	st birthday)	If Under Months	1 Year Days	If Under	24 Hrs. 8 Min.	Date of Birth Month, Day, Apr. 8	Year)	9. Birth	place (State or Foreign
ы	Director		285-38-7799	1 □ M 2 <b>X</b> □ F	83	Yrs.					Apr.8	,192	2 116	eland
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	Mary f sho	to	MD Monte	gomery		Ger	mant	own						1 XYes 2 No
	or 28a	irec	10e. Street and Number				10f. Zip				1	_	en of What Cou	
	23a c ust b	ral	21000 Fath						874		**************************************		U.S.A	
	er dea items	<b>Funeral Director</b>	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Marr</li></ul>	Armed Force		. 13.	Was Deced If Yes, spec	dent of His cify Cuba	spanic On n, Mexicar	gin? (Speci 1, Puerto Ri	fy Yes or No- ican, etc.)	14	Black, White	
36	be filed within 72 hours after death with the Maryland that Hyglene.  ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	3 ☐ Widowed 4 ☑ Divorced	If Ves Give			1 ☐ Yes 2	2 <mark>∳</mark> No	Specify:			S	Specify: Wh:	ite
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21	ithin 7 ne. ran "r e Med	mple	Elementary/Secondary (0-12)	College (1-4	lor 5+)	`life.							Home	
121	filed within Hygiene. other than "		12th Homemaker Home  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)											
Maryland 21215-0036	2 should be filed and Mental Hygi Is marked other aumatic event, the	o Be	John Grace						Mar	у Ке	llette	er		
ary I	shoul	မ	19a. Informant's Name/Relations	hip (Type. Print)									Town, State, 2	
	1 and 2 s Health ar tem 27 ls		Barbara Var	gas (Daug										MD 20874
Baltimore,	ges 1 and 2 should it of Health and Mer If item 27 is marke or other traumatic		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from S		nce of Dispo metery, cre				Da			ation - City or	
ţ	tment tant:		4 □ Donation 5 □ Other (S	Specify)	Arc	dent					√08		over,	MD HOME, P.A.
Bal	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		21. Signatur of Funeral Service	LICE AL	med	( XL	246 N	J. W	ashi	nato	n St.	Rock	ville	MD 20850
蒙			23a. Part1. Enter the disease, shock, or heart failure. List	complications that ca	used the death.									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	torily one cause on ea		EPS								Onset and Death
	/Medical		resulting in death)		r as a conseque	ence of):								
	Examiner	_	Sequentially list conditions,	D	/AIW	-	T	LA	CT	IN	FECT	lon		
-	bed Isit	Examiner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events	200.00 (0	t as a tictimatic	erice org.								
,	te be executed ysician and ie burial-transit	Exar	that initiated events resulting in death) Last	cDue to (c	r as a conseque	ence of):								
760,	ate be executed hysician and he burial-transit	cal		d										
89	ng h	Medi	IF FEMALE:											_
Box	requires that the death certificat een signed by the ettending thy nould be detached or use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?		rth 2 Fetal	death 3	⊒Ectopic p		/			2:	3d. Date of del Month	ivery Day Year
	he de the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□Unkno	ant at time of de wn	am o	Other (st	pecny/						
, P.O	w requires that the de been signed by the should be detached		Part II. Other significant condit	ions contributing to dea	ath but not resul	Iting in the u	underlying o	cause giv	en in Part	l.	23e. Did to	obacco us	se contribute to	the cause of death?
Records,	quires in sigr uld be	q pe									10)	/es 2) <u>≥</u>	gr̂No 3∏Pi	robably 4 Unknown
ဝင္ပ	~ 0 70	plete									24a. Was	osy	prior to	utopsy findings available completion of cause of
Ä	The law ate has b page 2 st	Completed by									perfo 1∐ Yes	rmed? 2 No	death? 1 ☐ Yes	2 <b>1</b> 0
Vital	iclan: sertific ector,	Be	25. Was case referred to medica examiner?	Hospital:				OA Oth	or .		(Check only o			
or	Physician: this certific ral director,	<u>1</u>	1 Yes 2 No 27. Manner of Death	1 ☐ Ir	npatient 2 E	28b. Time		OA   Onition   OA   OA   OA   OA   OA   OA   OA   O	4/20 N		ne 5 Residente la		Other (Spe	ecify)
On	ding h. After funer	tion	1 Matural 5 ☐ Pendi	/Mont	h, Day Year)	Injury	М		ń? Yes 2 ⊑	]No				
Division or	Attending I r death. ector: After by the funer	ifica	3□ Suicide 6□ Could	min ad Zoe. Flace	of injury - At hor ng, etc. (Specify		treet, factor	ry, office		2	8f. Location (8			ural Route Number,
	s after al Dire	Certification:												
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To the Il Examiner: On the ba and mann	sis of examinat	vledge, dea ion and/or i	th occurred nvestigation	dat the ti n, in my	me, date a opinion, de	and place, a eath occurre	and due to the ed at the time,	date and	and manner a place, and du	s stated. e to the cause(s)
	the ithin 2 the orthe orthelei	Medical	29b. Signature and title of certifi		ler stated.		29	c. Licens	se number			29d. Date	e signed (Mon	th, Day, Year)
	With Con			Bus	ms		}	D	00	57	124		8 (8	108
~	_		30. Name and address of person	n who completed cause	e of death (Item	23a) (Type	, Print)							
			Truong Boa,		110 Mo		lar :	Driv	ле, :	Rock	ville,	, MD	20850	)
		ate	31. Date filed (Month, Day, Year AUG 0	7 2008 32. 1	gistrar's Signat	ture	hast	9						
	Regist	udl'	AUG V	. 2000	BELLES J	0- 19	The state of the s							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month JONES **Physician** JARNET AUGUST 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** Bulti More If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days -46-81 3 Director h1100018 1A Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If them 27 is marked other than "natural", or thams not any Injury or other trainment. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Somerset 1 res 2 No RION Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 3 Funeral Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No BIACK Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ORENA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 5 Other (Specify) Signature of Fineral Service Licensee 22. Name and Address of Facility 917 W. Salisbury MD DISOI Bennie Smith Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ESPIRATORY **Physician** DAY disease or condition resulting in death) /Medical to (or as a consequence of) Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed bunial-transit Due to (or as a consequence of) resulting in death) Last attending physician Box 68760 Physician/Medical been signed by the attending pl should be detached for use as: IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) 9. 0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **2** Division of Vital Records. RENAL 4 Unknown 2 No 3 Probably 1 Tyes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I 2 No 2 No 1 TYes Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) filled in by the funeral director, Be Other: 4 \( \triangle \text{Nursing Home} \) 5 \( \triangle \text{Residence} \) 6 \( \triangle \text{Other} \( \text{(Specify)} \) 1 ☐ Yes 2 ☐ No 1X Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death
1 Natural
2 Accident Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely

31. Date filed (Month, Day, Year) State AUG 0 Registrar

29b. Signature and title of certifier

one)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

RECINCS JOHNS KORK 32. Resistrar's Signature

HOPKINS HOSPITAL 600 North Wolfe St, Baltimore, MD, 21287 2NHO.

ES-000

29c. License number

29d. Date signed (Month, Day, Year)

tu qust

			1 - State Registrar	of Maryland		artment of F rtificate of I		-	_	2008	27029
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic Examir		Virginia May Keyser  4a. Facility Name (If not institution, give street and it	number)		4b. City, Town, or	Location of Deat	August	5 4c.	2008 County of Death	4:55 A <sup>M</sup>
	Funeral Director		Homewood at Williamspor  5. Social Security Number 6. Sex 2 1 1 M 2 5 F	T. Age (In vrs. la	ast birthday) Yrs.	Williams If Under 1 Year Months Days		8. Date of Bir	th y, Year)	ashingtor 9. Birthpi Coun 13 Mary 1	lace (State or Foreign try)
	aryland show		Usual Residence of Decedent  10a. State 10b. County		, Town or Lo	cation	<u>_</u>			10	Od. Inside City Limits
	8a-f s	Director	Maryland Washington Cou	nty Hage	erstow						1 □Yes 2 ☐No
	3a or 2	μÖ	10e. Street and Number 12902 Oak Hill Ave.			10f. Zip Code 217	'42		10g. Citi	zen of What Count	try'?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygene. I health and Mental Hygene. I have 23 a or 28a-f show titem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Example required at	by Funeral	11 Marital Status 12. Was De	cedent Ever in U.S Forces? 2 2 No Give Dates:	- 1	Nas Decedent of H fYes, specify Cuba I □Yes 2 🛣 No		pecity Yes or No o Rican, etc.)		14. Race - America Black, White, e Specify: Whi	etc.
21215-0036	filed within 72 ho Hygiene. other than "natur ent, 'n. "kefeal i	Completed by	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College	(1-4or 5+)	(Give life. l	dent's Usual Occup kind of work done o DO NOT use retired ESS Owner	during most of wor f)	king		nd of Business/Ind	·
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ore	0 0 <del></del>		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Removal from	n State Ce	metery, cren	sition (Name of natory or other place		Date		cation - City or To	
Baltimore,	permit. Page Department o Important: If any Injury or once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Kes		en Cemete  . Name and Addres	- 1	-2008   uglas A	-	•	Maryland al Home
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ł	Physician /Medical Examiner			caused the death each line.	lero K	er the mode of dyin		/		lisen	Approximate Interval Between Onset and Death
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Division	i g fe o	Certification:		ce of Injury - At hor ding, etc. (Specify		eet, factory, office		28f. Location (: City or To	Street an vn, State	d Number or Rura )	l Route Number,
	e Hospital 24 hours a e Funerai I letely filled	edical	29a. Certifier (Check only one)  1 Certifying Physician: To t  2 Medical Examiner: On the and ma	he best of my know basis of examinati anner stated.	vledge, death ion and/or in	n occurred at the tirvestigation, in my o	ne, date and place pinion, death occu	e, and due to the irred at the time,	cause(s) date and	and manner as si place, and due to	tated. the cause(s)
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		-	30. Name and address of person who completed ca	use of death (Item	23a) <b>A</b> irne	Print) ·	COSE	6	Mu	gust 11	, 2008
A	1.3		A law Dyami	13451	(Pan	Walteria	Due	Heap	da.	- M	, 2008 21742
	Sta Registr		31. Date filed Month, Day, Year) ( 7 32.	Registrar's Signati	K A	parties				- V -	V

			State of Maryland / E State of Maryland / E State of Maryland / E Registrar Amended #24perMD FCHD, KS 8/8	Department of Health and Men <i>Gertificate of Death</i>	tal Hygiene	800	27030
F	Physici	an	1. Decedent's Name (First, Middle, Last)	2. [	Date of Death Month Day	Year	3. Time of Death
	/Media	cal	Doris E. Kelly  4a. Facility Name (If not institution, give street and number)		uly 24,	2008 County of Death	3 P. M
)	Examir	ner	Citizens Nursing Home	Frederick		Frederi	ick
ear (v)	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bird	If the dead Vene Total Landon Od the Long	Date of Birth (Month, Dav. Year)	T	place (State or Foreign ASS
H	Director		010-15-0159	115. J	an. 16,1	19 <b>1</b> 9 MA	ASS
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	the Ma 28a-f s optified	Director	MD Washington  10e. Street and Number	Boonsboro  10f. Zip Code	10g Citize	en of What Cour	1 ☐ Yes 2X No
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lary	2 should had had had had had had had had had ha	[		Mailing Address (Street and Number or Rural Ro			
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ē E	Pages nent of int; If II		1 □ Burial <b>XX</b> Cremation 3 □ Removal from State Smit Society	y, crematory or other place) hsburg Crematory7/2	6/08Smit	hsbur	g, MD
Бапптог	permit. Pages 1 and 2 should by Department of Health and Menta Important; If Item 27 is marked any Injury or other traumatic enone.		21. Signature of Funeral Syrvice Licentee	22 Name and Address of Facility Donald B. Thompso POB 18. Middletow	n Funera	11 Home	e
ì	#		23at Part1. Enter the disease, or complications that caused the death. Do n shock, of heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac or res	spiratory arrest,		Approximate Interval Between Onset and Death
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о. Бох	death atter d for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2→No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23	3d. Date of delive Month	ery Day Year
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		Be Co	25. Was case referred to medical	26. Place of Death (Cr	1□ Yes 2 XNo	1 ☐ Yes	<del>2</del> BNo
<u> </u>	> 02 73	To B		tpatient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6	□Other (Speci	fy)
	ne fte		1 Natural 5 Pending (Month, Day Year) I	Fime of njury at Work? 28d. Injury at Work? 28d. 1 ☐ Yes 2 ☐ No	Describe how injury	occurred	
UIVISION	I or Attending after death. Director: After I in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, fa building, etc. (Specify)	rm, street, factory, office 28f.	Location (Street and City or Town, State)	Number or Run	al Route Number,
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.				
	To the within To the comp	Me	29b. Signature and title of certifier Reilly 761	29c. License number 054749	29d. Date	signed (Month,	, Day, Year)
	Le		30. Name and address of person who completed causgot wath (Item 23a) of All EN KS LLLY, Washington South	(d) House Ave A	D-1 FREE	Derick	MA21701
	Sta Registi		31. Date filed (Month, Day, Year)  AUG 9 8 2008	G. Sparle		•	

DHMH 17 Rev 1/2001

**ORIGINAL** 

Division of Vital Records, P.O. Box 68760,

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Thomas Anthony Lewis 2008 /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6 Arden Road Ceci1 North East Year | If Under 24 Hrs. | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F Vrs Director 90 June 8,1918 New York 096-07-5848 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Ceci1 North East 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 6 Arden Road United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Comptroller Metro 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ೭ Benjamin Lewis Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William E. Lewis / Son 19 Pine Lane, North East, Maryland 21901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) August 12, 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 Removal from State 2008 Saints Cemetery Wilmington, Delaware 21. Signature of Sineral Service 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** DILICIY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner umphoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? (es 2 No death? 2 No il or Attending Physician: after death. I Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

11:40

1 ☐Yes 2 No

Approximate Interval Between Onset and Death

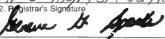
29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) AUG 1 2008 1

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

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Division or Vital Records, P.O. Box 68760,

		1 - State Registrar Certificate of Death					Reg. No. 2008 2/03					
		1. Decedent's Name (First, Middle, Last,	)				Date of Death     Month	Date of Death 3. Time of Death				
Physic /Medi		BARBARA JULIAN	NA MINTON				AUGUST					
Exami		4a. Facility Name (If not institution, give	•		4b. City, Town, or	r Location of Death		4c. County of De	ath			
		FORT WASHINGTO			FORT	WASHING If Under 24 Hrs.		PRINCE (				
Funeral Director		5. Social Security Number 6. Se. 163-30-7405 1 C	7. Age (In yrs. lat		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 11 – 11 –	1929 PA	rthplace (State or Foreign Country)			
land		10a. State 10b. County	10c. City,	Town or Loca	ation				10d. Inside City Limits			
Mary -f sho ied a	ξ	MD. CHARLES	S		1 ☐ Yes 2 No							
r 28a notif	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	Country?			
h with	Funeral Director	8504 ABELL WAY			20	603	U	.S.A.				
ems (		11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. 13. W		lispanic Origin? (Span, Mexican, Puerto		14. Race - Am				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	- 1	□Yes 2√2 No	Specify:	, , , , , , , , , , , , , , , , , , , ,					
in 72 h ''natu ledical	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give ki	nt's Usual Occup ind of work done of O NOT use retired	during most of work	ing 1	6b. Kind of Busines	s/Industry			
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illed Hyg other ent, 1	Be C	17. Father's Name (First, Middle, Last)							<u>,                                      </u>			
uld be denta rked ric ev	To B	RICHARD BALO	G			MARGARI	ET BALO	3				
should be should	-	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailing	Address (Street	and Number or Run	al Route Number,	City or Town, State,	Zip Code)			
and 2 ealth n 27 i		WALTER MINTON-	SON	8504	ABELL	WAY WA	LDORF, M	D. 20603	3			
of He of He fiten		20a. Method of Disposition	20b. Pla	ce of Disposi metery, crema	tion (Name of atory or other place	· · · · · · · · · · · · · · · · · · ·	Date 2	Oc. Location - City of	r Town, State			
Pag ment ant: I		4 □ Donation 5 □ Other (Specify)	emoval nom same TROP	POLITA	AN CREM	ATORY 8-	-20-08	ALEX., VA	۸.			
permit. Departimont import any Inj		21. Signature of Funeral Service Licens	™ M00479	22 R Z L Z	Name and Addres AYMOND A PLATA	ss of Facility FUNERAL , MARYLAI	SERVIC	E,P.A.				
7 THE 1		23a. Part1. Enter the disease, or complications that cause the death. Do not inter the mode of dying, such as cardiac or respiratory arrest.  Approximate										
Physician												
/Medical		resulting in death)  Due to (or as a consequence of):										
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  19472										
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oe ex		resulting in death, East	Due to (or as a conseque	ence of):								
icate be executed physician and s the burial-transit	Medical		d				<del></del>					
ding l		IF FEMALE:	3c. If yes, outcome pf pregnant	CV								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit	Physician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	leath 3⊟E	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year			
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To the vithing of the complete	M	29b. Signature and title of certifier	Farm MI	$\overline{}$	29c. License	2-2-37	MD 29	d. Date signed (Mod	nth, Day, Year)			
		01115	ompleted cause of death (Item 2	3a) (Type, Pr	rint)		Specify: WHITE  16b. Kind of Business/Industry  OWN HOME  NARET BALOG  Flural Route Number, City or Town, State, Zip Code)  VALDORF, MD. 20603  Date 20c. Location - City or Town, State  8-20-08 ALEX., VA.  AL SERVICE, P.A.  diac or respiratory arrest, Approximate Interval Between Onset and Death  30 - 6 s mm >  10 y Carrest  Approximate Interval Between Onset and Death  30 - 6 s mm >  23d. Date of delivery Month Day Year  23e. Did tobacco use contribute to the cause of death?  1 yes 2 No 3 Probably 4 Unknown  24a. Was an 24b. Were autopsy findings available					
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Sta Registr		31. Date filed (Month, Day, Year) AUG 2 1 2008	Se. negisirar s Signatu	Speak	5							

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45	Physici	on	1. Decedent's Name (First,	Middle, L	ast)					2. Date of D	Death	y Year	3. Time o	f Death
	/Medi		Martha Eliza							AUGUST			10:20	A M
	Examir	ner	4a. Facility Name (If not inst			er)			or Location of De	eath	1	County of Death		
			Memorial Ho 5. Social Security Number			A //-		Cumber1		lm   0 D. I. (5		Llegany		
ŀ	Funeral Director		215-20-5054 Usual Residence of Decede		Sex 7. 1 □ M 2 ▼ F	Age (In yrs.	last birthday) Yrs.	Months Days			Day, Year)	Cot	place (State intry) Land	or Foreign
	land ow		10a. State 10b. Co			10c. Cit	ty, Town or Lo	ocation					10d. Inside C	ity Limits
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	th the	irec	10e. Street and Number					10f. Zip Code			10g. Cit	izen of What Cou	intry?	
	23a c	la L	100 Honeysuck	cle	Apt. 420			21532			Unit	ed State	es	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □  3 ■ Widowed 4 □ Divi		12. Was Deceded Armed Force 1 Tes 2 If Yes, Give Year or Date	es? <b>⊠</b> No		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☐ No		(Specify Yes or Nerto Rican, etc.)	No-	14. Race - Amer Black, White Specify: Wh		
5-0	72 hc 'natu	etec	15. Dec (Specify only)	edent's E	ducation ade completed)		16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation during most of v	vorking	16b. K	ind of Business/I	ndustry	
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Baltimore,	permit. Pages 1 and 2 Department of Health Important; If item 27 any Injury or other tra		21. Signature of Funeral Se	21.	owers	Mcn 5	2 60	2. Name and Addr	ess of Facility	Sowers F	unera	J Home,	P.A.	
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Records,	e law has b je 2 st	Completed by								24a. Wa	as an topsy rformed?	24b. Were au prior to death?	topsy findings completion of	available cause of
ta			25. Was case referred to m	edical					00 Pl 4 F	1□ Yes	2 DAG		2 No	
>	Physician: this certificral director,	To Be	examiner? 1 ☐ Yes 2 ☑ No	Jaroar	Hospital:	atient 2 🗆	ER/Outpatie	nt 3□DOA Ot	hor	Death <i>(Check onl</i> g Home 5 ☐ Re		€ ∏Other (Spec		-
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Division or Vital	after de l Directo d in by th	Certification:		ould not l etermined	28e. Place of	injury - At he , etc. <i>(Specil</i>	ome, farm, st	reet, factory, office			(Street ar Fown, State	nd Number or Ru e)	ral Route Nu	mber,
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	To the complete th	Ž	29b. Signature and title of c	ertifier				29c. Licen	se number		29d. Da	ate signed (Monti	n, Day, Year)	·
			////		A 3 CIF	JAHI	M.D		6660	6	AUGI	JST 1	7 20	08
-			30. Name and address of p	erson who	completed cause	of death (Iter	n 23a) (Type,	Print)					- 5	11.1
			Dr. Olaide I			Seton		Cumber1ar	id, MD	21502				
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Registrar DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8 **Physician** 2008 11:02 P M M. Gennette Butler McCabe /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Atlantic General Hospital Berlin 8. Date of Birth (Month, Day, Year) 9/17/1926 5. Social Security Number If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min 218-20-9393 MD 81 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marical Examilier arms it can cultiled at once. 1 ∏Yes 2 TXNo Director MD Worcester Berlin 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 1 Meadow St. Apt. 205 21811 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 🗓 No Completed by Specify: Specify: 3 X Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Apartment Building 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elton T. Butler Ella Kee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5623 Mountville Rd., Adamstown, MD 21710 Thomas McCabe/ son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Cemetery 8/9/2008 Berlin, MD 4 ☐ Donation 5 ☐ Opher (Specify) 22. Name and Address of Facility Burbage Funeral Home Service License 108 William St., Berlin, MD 21811 23a. Part . Enter the frease, of complications that shock, or heart failure. List only one cause of Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): 68760, Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) cate has been signed by the a page 2 should be detached in 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy The 2 spital or Attending Physician: The hours after death.
neral Director: After this certificate y filled in by the funeral director, par 1 ☐ Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 8 Name and address of person w Date filed (Month, Day

State Registrar

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		1 - For State Registrar	State of Marylan	•	artmen rtificat				Re	eg. No.	008	27036			
Physicia /Medic		1. Decedent's Name (First, Middle, Last, Robert Leonard I	Mimms, Jr.						2. Date of Deat Month	Day	Year 200 g	3. Time of Death			
Examin	er	4a. Facility Name (If not institution, give Future Care Ches	apeake		Ar	no1d	Location of			A	ounty of Deat	undel			
Funeral Director		5. Social Security Number 6. Set 219–10–7652	7. Age (In yrs.)	Yrs.	If Under Months	Days	Hours	Min.	8. Date of Birth (Month, Day, 2/7/19	28	Ma.	hplace (State or Foreigr untry) ryland			
permit. Pages 1 and 2 should be tited within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23e or 28a-f show eny injury or other treumatic event, The Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10b. County  Maryland Anne Ari 10e. Street and Number  1842 St. Margare  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Ed.  (Specify only highest grade  Elementary/Secondary (0-12) 12th  17. Father's Name (First, Middle, Last) Robert L. M  19a. Informant's Name/Relationship (T) Bonnie Jarrell/ D.  20a. Method of Disposition 1 M Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)  21. Signatur Justa Pervice cens	ts Road  12. Was Decedent Ever in U. Armed Forces? 1 (MYes 2 C) No if Yes, Give Year or Dates: 1945—cation e completed)  College (1-4or 5+)  imms, Sr.  pe, Print)  aughter  Aemoval from State	16a. Dece (Give life.) Anne A 19b. Mailii 6920 emetery, cres Vetera	Olis  10f. Zip  Was Dece If Yes, spe  I Yes kind of wo bo NOT u  Arund  Arund  Arund  O Sta  Disting (Na malory or G  ans C	dent of Hicry Cuba  2 No  And	spanic Origin, Mexican, Mexican, Specify:  ation specify:  18. Mother F.  and Number Rd., ]	of working of working of the second of the s	man  (First, Middle, Ince Will  (Foote Number ton, MD)	US  16b. Kind  Law  Maiden S  liams  r, City or  2165  20c. Loc.	Race - Ame Black, White Specify: Will d of Business  Enforce tumame) S  Town, State, 155 ation - City or	orican Indian, e, etc.  nite  Vindustry  Cement  Zip Code)			
Cate be executed /Medical Examiner    Ithe burial-transit    Ithe bu	ted by Physician/Medical Examiner	by Physician/Medical	by Physician/Medical	al Examiner	flary leading to immediate cause. Enter Underlying Cause (Disease or injury	ications that caused the deather cause on each line.  a. Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of:						est,		Approximate Interval Between Onset and Death
that the death certifi ed by the attending detached for use as				in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant conditions co	23c. If yes, outcome of pregnation of the pregnant at time of dependent of the pregnant at time of dependent of the pregnant at time of dependent of the pregnant of the pregn	I death 3[ eath 5[ ulting in the u	, ,	cause giv	en in Part I.		23e. Did to	obacco us		livery Day Year o the cause of death? robably 4 □Unknow	
The la ste has bage 2	Completed				,				opsy prior to completion of cau formed? death? 2 No 1 ☐ Yes 2 ☐ No		completion of cause of				
il or Attending Physicien: T efter death. Director: After this certificet In by the funeral director, pa	Certification: To Be	25. Was case referred to medical examiner?  1	examiner?  1						ome 5 Residence 6 Other (Specify)  28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route City or Town, State)						
To the Hospital or Atta within 24 hours effer de To the Funeral Directo completely filled in by th	dicai Ce	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my knotiner: On the basis of examina and manner stated.	owledge, deal	th occurred	at the tir	ne, date an pinion, dea	d place, a	and due to the ded at the time, t	cause(s) a	and manner a place, and du	s stated. e to the cause(s)			
To the within To the comple	Med	29b. Signature and title of certifier	md				e number	31				oth, Day, Year)			
عالاً الم Sta Registr	te	30. Name and address of pers. 1 who constituted a second a s	8601 VUT	Yan S	Print)	7,50	rete	200	1 Mi	yer.	sville	m) 2110			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 9:20 A M Margaret L. Maloney 5, 2008 August /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel South River Rehabilitation Center Edgewater If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛣 F 8/10/1919 88 Virginia Director 162-09-8036 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland | Anne Arundel Lothian 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code an "natural", or Items 23a or Medical Examiner must be USA 20711 117 Konrad Morgan Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7 is marked other tha traumatic event, the Department Store 12th Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any linity or other traumatic event orce. Be Herman Brown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) George E. Maloney/ Husband 117 Konrad Morgan Way, Lothian, MD 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Cemetery 8-8-08 Davidsonville, MD 21. Signati Sept & Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardio Vasculan dismose **Physician** Atheroscienotic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, Examiner certificate be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical as attending IE FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should peen Congestive 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed: Dementia 2 110 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 1 Inpatient 은 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident death within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

5851.

31. Date filed (Month, Day, Year)

a.C

Deale

AUG 0 6 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Saltimore,

P.O. Box 68760.

Division or Vital

hurcht

Registrar's Signature

50653

GYAN C.

Road

D 50653

20751

SURANA

		For State of Maryland	/ Department of Health  Certificate of Death	n and Mental Hyg	giene 2008 27038
	_	Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Dea	th 3. Time of Death
Physic /Medi		WILLIAM	NORRIS	Month 0.7	Day Year M 0700
Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Locatio		4c. County of Death
		WMHS-BRADDOCK CAMPUS  5. Social Security Number   6. Sex   7. Age (In yrs. lax	CUMBERLAND st birthday) If Under 1 Year   If Und	ler 24 Hrs.   8. Date of Birt	ALLEGANY h 9. Birthplace (State or Foreign
Funeral Director		220-30-8210 1× M 2 F 71	Yrs. Months Days Hours		, 1937 MD
p v		Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Location		10d. Inside City Limits
Maryla f shov	ō	MD Allegany	Cumberland		1 <b>x</b> □Yes 2□No
r 28a-	Director	10e. Street and Number	10f. Zip Code	1	10g. Citizen of What Country?
th with	ralD	707 Baker Street	215		USA
paritinition in war ylating £15.15-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantral and context.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No  If Yes, Give  Year or Dates:	13. Was Decedent of Hispanic of If Yes, specify Cuban, Mexic		14. Race - American Indian, Black, White, etc.  Specify: white
72 hot	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during m life. DO NOT use retired)	nost of working	16b. Kind of Business/Industry
within within than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	laborer		MD National Guard
filed v Hygic Sther	Be Co	17. Father's Name (First, Middle, Last)	18. Mo	other's Name (First, Middle,	Maiden Surname)
should be ind Mental in marked o	To B	William B. Norris		mma Fields	Norris
and 2 sho ealth and I n 27 is me		19a. Informant's Name/Relationship (Type. Print) Frances Norris wife	19b. Mailing Address (Street and Nur 707 Baker Street	mber or Rural Route Number Cum	er, City or Town, State, Zin Code) berland MD 21502
this of the transfer of the tr		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	ice of Disposition (Name of metery, crematory or other place) awn Memorial Gardens	Date 7/31/2008	LaVale MD
permit. Departi Importa any Inju		21. Signature of Funeral Service Licensee	22. Name <b>Staffelff Fun</b> 108 Virginia A	ଝାରୀ Home, PA Avenue: Cumberla	nd, MD 21502
		23a. Part 1. Enter the taisease, or complications that caused the death. shock, of heart failure. List only one cause on each line.	TM # 4520		Onset and Death
Physician /Medical		Immediate Cause (Final disease of condition resulting in death)		Liver Meta	stasis yrs.
Examiner		Due in (or as a conseque	Tumor on Left	side	
B #	Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events conditions and the conditions of the conditi		3100	
ecuter and -transi	Examiner	Cause (Disease or injury that initiated events c.	and officer		
icate be executed physician and the burial-transit	<u>8</u>	resulting in death) Last Due to (or as a conseque	rice or).		
oo/ tificate g phys	edical	d			
th cert tendin	an/M	IF FEMALE: 23c. If yes, outcome of pregnant   23c. If yes, outcome of pregnant   1 □ Live birth   2 □ Fetal (			23d. Date of delivery  Month Day Year
dS, F.O. DOX of ires that the death certiful signed by the attending doe detached for use as	Physician/M	in the past 12 months?  1   Yes   2   No   4   Pregnant at time of de   9   Unknown   9   Unknown			Month Day Year
that the ned by detac		Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Pa	art I. 23e. Did t	obacco use contribute to the cause of death?
requires to been signed should be	ed by	COPD		1 🗹	Yes 2 No 3 Probably 4 Unknown
ding Physician: The law requires that the death certif.  After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	Completed			24a. Was	psy prior to completion of cause of
t: The	S				ormed? death? 2 ☑ No 1 ☐ Yes 2 ☑ No
VICAL slclan: ] certifica irector, p	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☑ Inpatient 2 ☐ E	Other	lace of Death (Check only o	dence 6 ☐ Other (Specify)
g Phy g Phy er this		27. Manny of Death 28a. Date of Injury	28b. Time of Injury Work?		how injury occurred
Attending For death. ector: After by the funer	atio	2 Accident investigation	M 1 □Yes 2	! □No	
or Att after de Direct in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At hor building, etc. (Specify,	ne, farm, street, factory, office	28f. Location ( City or To	Street and Number or Rural Route Number, wn, State)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	vledge, death occurred at the time, date on and/or investigation, in my opinion,	e and place, and due to the death occurred at the time	cause(s) and manner as stated. date and place, and due to the cause(s)
To the within To the comple	Mec	29b. Signature and title of certifier	29c. License numb	er	29d. Date signed (Month, Day, Year)
		Deur Calke	SWD \$ 544	/ []	July 26, 2008
•		3a. Name and address of person who completed cause of death (Item	1 6	(11	N. 1. 1 21500
SI	tate	31. Date filed (Month, Da) Year) 32. Regignar's Signature		umberland,	Maryland 21502
Regis	trar	AUG 2 1 2008 Steemen	is appeared		•

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** August 2008 Khandubhai V. Patel 1501 /Medical Aa. Facility Name (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL 4c. County of Death 4b. City, Town, or Location of Death Examiner Wicomico alisburu 8. Date of Birth (Month, Day, Year) Nov 1, 1949 Social Security Number Birthplace (State or Foreign Country) **Funeral** Min. Months 1 ☑ M 2 □ F Hours 758-01-2646 58 Director India Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location Department of Health and Mental Hygiene, instural, or items 23a or 28a-f show Important; if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantiner must be notified at any injury or other traumatic event, the Medical Evantiner must be notified at any once. XXYes 2 No Director VΑ Chincoteague Island Accomack 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23336 6273 Maddox Blvd. India Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2X Married 2 X No 1 ☐Yes 2 No Specify. Specify: Indian Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Motel Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental Vasantbhai Patel Laxmiben Patel ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Atul Patel- Son 4044 Church Point Rd. Virginia Beach, VA 23455 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State Lynnhaven Crematory 8-7-08 Virginia Beach, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Holloway Funeral Home P.A.
501 Snow Hill Rd.Salisbury, Maryland 21804 ature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unicease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): physician the burial Box 68760. Physician/Medical attending p IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a d be detached for Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by icate has been sig 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No Division of Vital 1 ☐ Yes Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatur 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature Soyde St. Salisbury Ma Day, Year) State AUG Registrar

DHMH 17 Rev 1/2001

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			For State Registrar	State of Maryla		artment of H rtificate of L			gienez () () ( Reg. No.	8 27040
ì	Physici		1. Decedent's Name (First, Middle, Last)	PAYNE				2. Date of De Month	Day Yea	PS - W 14
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give s  ANCHORAGE NU  5. Social Security Number  218-20-4290  1	reet and number)  75 NG Cent  7. Age (In yrs	S. last birthday)	4b. City, Town, or SAL  If Under 1 Year  Months Days	if Under 24 Hrs. Hours Min.	8. Date of Bir	4c. County of Do	
	yland now at		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo					10d. Inside City Limits
	he Mar 8a-f sh otiffed	ector	MD Wicomic	0	Sa	lisbury			10-02	1 ☑Yes 2 ☐ No
	th with the 23a or 2	al Dir	10e. Street and Number 105 Times Squa	re		10f. Zip Code	21801		United S	-
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, /hite, etc. White
Maryland 21215-0036	I within 72 ho jene. r than "natur the Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired emaker	ation during most of wor d)	king	16b. Kind of Busine	,
yland 2	should be filed within and Mental Hygiene. s marked other than " umatic event, the Mes	To Be C	17. Father's Name (First, Middle, Last) Albert G. Steph	ens			Viola	Baker	, Maiden Surname)	
Mar	nd 2 sho Ith and 27 Is m		19a. Informant's Name/Relationship (Typ. Larry R. Scott,						er, City or Town, Stat	e, Zip Code) 19940 mar. DE
	ges 1 ar of Hea of Item 3		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	20b.	Place of Dispo	osition (Name of matory or other place	i	Date	20c. Location - City	or Town, State
Baltimore,	nit. Pag artment ortant: injury e		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	M		J. Meth. ( 2. Name and Addres		, ,	Delmar, Ma	•
Ba	permi Depai Impoi any ir	5_7/5	+ Poloule_	CFSP					Funeral Ho MD 21632	_
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it any leading the first bridge lists of the factors of the first of the factors of the first of the factors of the fa	Due to (or as a more	rant equence of):		l astom		illest,	Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	edical Examiner	frank, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
.O. Box	death certif e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf preg 1 □Live birth 2 □Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i> _	/		23d. Date of Month	delivery Day Year
ords, P	sigr d be	by	Part II. Other significant conditions con	tributing to death but not re	esulting in the u	ınderlying cause giv	en in Part I.		/	e to the cause of death?  Probably 4 Unknown
al Records,	The law ate has b page 2 s	Completed						24a. Was auto perf 1□ Yes	ppsy prior ormed? deat	e autopsy findings available to completion of cause of h? Yes 2 □ No
or Vital	Physiclan; Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	lospital: 1	□ ER/Outpatie	nt 3□ DOA Oth	26. Place of Dea		o <i>n</i> e) idence 6 □Other (3	Spacify)
ion or	fter fter ne	Certification: To	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injur Wor		T	how injury occurred	эреспу
Division	al or Att	ertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At building, etc. (Spec	home, farm, st cify)	reet, factory, office		28f. Location ( City or To	(Street and Number o wn, State)	r Rural Route Number,
	To the Hospital or Attendil within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	ledical C		sician: To the best of my k ner: On the basis of exami and manner stated.						
	To th withir To th comp	Me	29b. Signature and title of certifier	N.D.		29c. Licens	_	7	29d. Date signed (M	1
			30. Name and address of person who co		em 23a) (Type	Print)	5 795	_	00/0	7/08
			Babulal Da	1. MD.	106	MILFORD	ST. 5	ALISBUL	H, MD Z	1804
	Sta Regist		31. Date filed (Month, PAUG 1)	2008 <sup>32. Reg Grar's Sig</sup>	a all	A second	<b>?</b>			

Registrar

State

Chester River Hospital

30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

Registrar's Signature

		4	For State	State of Mary		partment of H <i>ertificate of L</i>				0.0	27012
[			Registrar  1. Decedent's Name (First, Middle, Last	1)		ertineate or E	Journ	2. Date of Dea		Uð	3. Time of Death
	Physicia	an		g Pernol, Si	r.			Month August	11, 20	08	11:20 A M
	/Medic Examin	- 4	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. Count	y of Death	
			Caroline Home for			Dento		0. Date of Birth		rolin	
	Funeral Director		222-36-3933	7. Age (// XM 2□F 57	In yrs. last birtho	Months   Davs	Hours Min.	8. Date of Birth (Month, Day April 2	Year)	Cour	place (State or Foreign htry) √are
	and w		Usual Residence of Decedent  10a. State 10b. County	10	0c. City, Town o	r Location		<u> </u>		1	0d. Inside City Limits
	Maryl -f sho ied a	tor	Maryland Caroline	ي ا	Greens	boro					1 X Yes 2 No
	r 28a	Director	10e. Street and Number			10f. Zip Code			l0g. Citizen of	What Cour	ntry?
	th wit	a D	303 Bernard Ave.			2163	-		U.S.		an Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants if Item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 【 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes ※ No	spanic Origin? (Sp in, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	Bla	ace - Americ ack, White, ify: Whi	etc.
21215-0036	nin 72 hou e. In "natura Medical E	Completed	15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)		ecedent's Usual Occup Give kind of work done of fe. DO NOT use retired	during most of work	ing	16b. Kind of I	Business/In	dustry
212	d with giene er tha , the l	등	12			rpenter		1000 A A A A A A A A		truct	ion
pu	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)			:	18. Mother's Nam				
yla	Men narke	은	George K. Pernol  19a. Informant's Name/Relationship (7)	Timo Print)	19h N	Mailing Address (Street		te Gody			p Code)
Maryland	d 2 sh th and 7 Is n traun		Martha Louise Per			Box 345; 0				1639	,
<u>ნ</u>	Heal tem 2		20a. Method of Disposition			isposition (Name of crematory or other place		Date	20c. Location	- City or T	own, State
DOE!	Pages ent of nt: If I		1 Magazian 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 5 □ Other (Specification Specification Specifi	Removal from State		boro Cemete		5/08	Greensb	oro,	Maryland
Baltimore,	permit. I Departm Importar any Inju		21. Signature of Funeral Service Licer	See Fel	/	22. Name and Addre Fleegle ar PO Box 160	ss of Facility d Helfen : Greens	bein Fur	neral H	lome 2163	PA 9
ĸ.			23a. Part1. Enter the disease, or com	plications that caused th	ne death. Do no						Approximate Interval Between
	Physician /Medical	8	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a c	astatio	malign	ant n	relano	m a		Onset and Death
	Examiner				consequence or						
1		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a r	consequence of	r				-	
	ecuted nd transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c		λ.				-	
30,	oe exe cian a vurial-l		resulting in death) cast	Due to (or as a	consequence of	):					
8760,	cate be executed physician and the bunal-transit	dical		n d							
.O. Box 6	ath certifi ttending or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) □	у			Date of deli	very Day Year
<u>α</u>	w requires that the de been signed by the a should be detached t	by	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying cause giv	ven in Part I.	23e. Did 1	./		the cause of death?
Records,	The law requate has been page 2 shoul	Completed						24a. Was auto perfo		prior to death?	topsy findings available completion of cause of
Vital	(0 17	a	25. Was case referred to medical				26. Place of Dea				
Z	nysic is ce direc	To B	examiner? 1 □ Yes 2 <b>17</b> No	Hospital: 1 ☐ Inpatient	t 2 ER/Out	oatient 3 DOA Otl	ner: 4 \sum Nursing H	lome 5 ☐ Res		Other (Spec	city) HOSPICE
n or	ding Ph After th funeral		27. Manner of Death  16至Natural 5 □ Pending	28a. Date of Injury (Month, Day	/ 28b. Ti	jury Wa		28d. Describe	how injury occ	curred	
sio	Attending r death. ector; After by the fune	catio	2 Accident investigatio 3 Suicide 6 Could not b		av - At home far	M 1 m, street, factory, office	]Yes 2□No	28f Location /	Street and Nu	mber or Ru	ıral Route Number,
Division	after d Direct	Certification:	4 Homicide determined		(Specify)	III, Street, Idolory, Office			wn, State)		
_	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier Check only one)	hyslcian: To the best of miner: On the basis of e and manner state	examination and	death occurred at the t l/or investigation, in my	ime, date and place opinion, death occ	e, and due to the urred at the time	cause(s) and , date and place	manner as ce, and due	s stated. e to the cause(s)
	To the Hos within 24 ho To the Fur completely	Mec	29b. Signature and title of certifier	11/.	,	29c. Licen			29d. Date sig	gned (Mont	
	C > E 0		1 27	SHI.	MD	000	u7534	MO	8	112	108
			an Name and address of person who	completed cause of deal	et, Der	Type, Print)  Hon, MD	21629				
	Si Regis	tate trar	31. Date filed (Month, Day, Year)  AUG 1 2	32. Registra	r's Signature	Anille					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Floring Property Registra Park No. 12 (2000) 10 (2000) 1 Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Shahid Mohammed Oazi Month Day **Physician** 8 55 AM 2008 August 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.

Dave Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) DEC 25, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 56 **Director** 1951 Pakistan Usual Residence of Decedent the Maryland 10a. State 10d. Inside City Limits 10c. City, Town or Location 28a-f show 1 ☐XYes 2 ☐ No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygene.
Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f s any Injury or other traumatte event, the Medical Examiner must be notified any Injury or other traumatte event, the Medical Examiner must be notified. Director Ontario Toronto 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 41 Rivers Edge Drive M6M5L4 Canada Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Š Specify: 3 Widowed 4 Divorced Indian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Private Software Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Software Developer Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abdul Hameed Qazi Quresha ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 41 Rivers Edge Drive Zeeshan Qazi, Son Toronto, Ontario 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State AUG. 4 ☐ Donation 5 ☐ Other (Specify) Maryland National M.P. 2008 Laurel, Maryland 22. Name and Address of Facility
Thibadeau Mortuary Service, P.A.
933 Gist Ave., LL, Silver Spring, MD 20910 21. Signature of Funeral Service Licensee Buin Mig En M01508 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Stroke /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed √To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

| Completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

| Completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

| Completely filled in by the funeral director. | Completely filled in the fil Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) ည 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. 1 Natural Injury 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ρ 2009 MD RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lolunda 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 07 AUG 2008 Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** PAUL ROBERT RITTER 3:18A AUGUST 10. 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ★ M 2 ☐ F July 12, 1935 Maryland 217-30-1635 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1XIYes 2 □ No Directo Frederick Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21701 Apt. 213 800 Motter Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏲 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: þ White 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) communication sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (unknown) Paul H. Ritter Elizabeth ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traunonce. Frederick, MD 21701 120 W. Church St. Daniel Tregoning/personal rep. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/20/2008 | Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Cemetery 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service L affarine New Windsor, MD 21776 310 Church St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final MINUTE **Physician** disease or condition resulting in death) /Medical ongertive Heart Pailure

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voric Oh Tructuc Pulmonary Dieene Due to (or as a to MONTHS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed and for use as the burial-trai Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 I Unknown 9 Unknown ģ s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an cate has t autopsy perform certificate 1 ☐ Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2XER/Outpatient 3 DOA 1 Yes 2 No 1 ☐ Inpatient After this c Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier/ DOOB 2223

State
Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

\*\*RAYEEN BICANUM, TO, 1967TOLIVE, FREDERICK, TO UTO2

32. Registrar's Signature

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			for State Registrar		Oldic	71 1410	ai yiai ia	•			Death		iornai i ij	Reg. No.				
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F	/Medic Examin		4a. Facility Name (li						4b. City,	Town, or	Location		1	4c. (	County of			_
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			30. Name and addr	ress of person	who completed cau	ise of d		23a) (Type,	Print)	LAT I	Ne	He	8 wlock	Well	2/	111	2	
	Sta		31. Date filed (Mon	AUG Year	2008	Registr	ar's Signatu	re	- 0/ /		-/	1/	7,/-		076	7	)	_
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Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Rea. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 08 Dorothy R'SSP M N Simms /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7319 Jannie Lane Brandywine Prince Georges 5. Social Security Number 8. Date of Birth (Month, Day, Year) 10/12/1912 If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 П м 2 🕅 Е Min. 214-28-4787 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1X Yes 2 No Director Maryland Prince Georges Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7319 Jannie Lane 20613 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: ð 3 ☑ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John 2 Louise 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Watkins/Daughter 7319 Jannie Lane Brandywine, Maryland 20613
ace of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) St. Mary's 8/11/08 Croom, Maryland 22. Name and Address of Facility Adams Funeral Home PA 21. Signature of Juneral Service Licenses 20605 Aquasco Rd. Aquasco, Maryland 20608 23a. of 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** UROSE /Medical Due to (or as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2⊠No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 
— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Division or Vital Records, P.O. To the Hospital or Attending Physician: " within 24 hours after death. To the Funeral Director: After this certifice compfetely

> State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Year)

**AUG** 0 7

29c. License number

29d. Date signed (Month, Day, Year)

GREENBELT, MARYLAND 2077C

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 7:10 Hendarwanto Sinarjoedo **p**M 2008 August 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days 1**⊠** M 2□ F Hours Yrs. Director February 22, 1946 213-29-1202 62 Indonesia Usual Residence of Decedent death with the Maryland 10a. State 10c, City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Mactical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9712 Washingtonian Blvd. 20878 Indonesia Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. should be filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: by 3 Widowed 4 Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Agent MVA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Sinarjoedo Kartosoedirdjo Soedarmilah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 Is n any Injury or other traun <u>once.</u> Marina Ranti - Spouse 9712 Washingtonian Blvd., Gaithersburg, Maryland 20878 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 

Burial 2 □ Cremation 3 □ Removal from State \* 4 □ Donation 5 □ Other (Specify) Parklawn Memorial Park 08/07/2008 Rockville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enjer the disease, or complications that caused the hock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760 the attending physician Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 Yes Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check onlone 1 Inpatient Other: 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After Hospitel or Attending 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Homst Hyatbuille 3415 Ham 31. Date filed (Month, Day, Year) State 32 Registrar's Signature AUG 07 2008 Registrar

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		Registrar  1. Decedent's Name (First, Middle	e, Last)						Date of Death Month		Year	3. Time	e of Death
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ral Director: After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial-transit of Certification: To Be Completed by Physician/Medical Examiner	leuical Certification: 10 be completed by ruysicial medical Examiner	Sequentially list conditions, acase. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions are aminer? 1   Yes 2   No   No   No   No   No   No   No	Due to b. Due to c. Due to d.   23c. If yes, or 1   Live 4   Prey 9   Unk ons contributing to or 28e. Place inned building to the Examiner: On the and ma	of or as a consequence or as a consequence or as a consequence of or as a consequence or a consequence or as a consequence or as a consequence or as a co	ence of):  ence of):  ence of):  ence of):  ency death 3 E eath 5 E  Iting in the u  ER/Outpatier 28b. Time o Injury Incomplete of the second	Ectopic pregnanc Other (specify)  Int 3 DOA Oth  Int 3 DOA Oth  If 28c. Injury  Wor  Int M 1 DOA  Teet, factory, office  The occurred at the tit   Zey ven in Part I.  26. Place oner: 4 □ Nurry at k?  I'ves 2 ☒ N  ime, date and opinion, deat se number	of Death (C) sing Home 28d do Pe U 28f.	23e. Did tob  1 Ye  24a. Was ar autops perform  1 Yes  2heck only one  5 Reside  1. Describe ho  1. String  1. Jest of the control of the con	23d. D	Intribute to  3 Property Prior to the Control of th	ivery Day  the cause obably  topsy find completion 2 \( \text{No} \)  or if \( \text{No} \)  a \( \text{Y} \)  is stated.  to the cause of the cause	Year e of death? 4 (X) Unknow ings available of cause of	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2000

		State     Registrar     Decedent's Name (First, Middle)	e, Last)	Cei	rtificate of Dea	2. Date of I		3. Time of Death
Physicia		Tha	ch Van Tran			Month August	Day Year t <b>06 2008</b>	
Medic/ Examin		4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, or Locat	ion of Death	4c. County of De	ath
		6068 Tree Sw	allow Court			umbia		Howard
uneral irector		5. Social Security Number <b>213-43-7677</b>	6. Sex 7. Ag	e (In yrs. last birthday)  63  Yrs.	If Under 1 Year If Un Months Days Hou	or 24 Hrs. 8. Date of 1 (Month, Januar)	Birth 9. B <i>Day, Year)</i> <b>y 20, 1945</b>	irthplace (State or Forei Country) <b>Vietnam</b>
M T		Usual Residence of Decedent  10a. State 10b. County	1	10c. City, Town or Lo	ocation			10d. Inside City Limi
-f show fed at	to		Howard	,	Columb	ia		1 X Yes 2 □ N
r 26a	Director	10e. Street and Number	nowaru		10f. Zip Code	10	10g. Citizen of What C	Oountry?
23a o		6068 Tree Sw	allow Court		21	044	Viet	nam
iten z'i is markou unter man maturar, o'n tems zoa or zoari smo other traumatic event, the Madical Exeminar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marr	If Yes, Give	NO I	Was Decedent of Hispanion of Yes, specify Cuban, Med 1 ☐ Yes 2 🗷 No Spe		No- 14. Race - An Black, Wh Specify:	
DALEX	ed b	3 ☐ Widowed 4 ☐ Divorced  15. Deceden	t's Education	16a. Dece	dent's Usual Occupation		16b. Kind of Busines	Asian s/Industry
Medi	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-4or 5	life	kind of work done during DO NOT use retired)	most of working	Ť	
T,			4		Lieutenant			amese Governme
even	Be	17. Father's Name (First, Middle,			18. M	Nother's Name (First, Midd		
mark	၉	19a. Informant's Name/Relations	Khoa Tran	19h Maili	ng Address (Street and No	Tai N		Zin Code)
em 27 is ma other trauma		Ha Tran - Daugh			Tree Swallow C			, ,
othe		20a. Method of Disposition	itei	_	osition (Name of matory or other place)	Date	20c. Location - City of	
Important: If Item 2 any Injury or other <u>once</u> .		1   Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	ipecify)	Meadowridge	e Memorial Park		Elkridge, N	laryland
any l		21. Signature of Funeral Service	Zicensee Williams	. 1	2. Name and Address of F Hines-Rinaldi F 11800 New Hamps	uneral Home. In	nc. ilver Spring, l	Maryland 2090
sician edical miner	,	23a. Part 1. Ente the disease, or shock, or P art failure. List Imm 15 to Lause (Final disease or condition resulting in death)	a. Metastat  Due to (or as	ine death. Do not en ne.  ic Salivary ( a consequence of):  to Thrive		n as cardiac or respirator	y arrest,	Approximate Interval Between Onset and Death Months
physician and the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate case. List of earling Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence of): a consequence of):				
by the aftending phached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ ∀es 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a	2 Fetal death 3 €	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of o	delivery Day Year
igned be de	by	Part II. Other significant condition	ons contributing to death b	ut not resulting in the u	underlying cause given in F		id tobacco use contribute ☐ Yes 2 ☐ No 3 ☐	
cate has been s page 2 should	Completed					pe	utopsy prior t erformed? death	
certificate rector, pag	a	25. Was case referred to medica examiner?	I Variable		26. F	l □ Ye Place of Death (Check on		es 2 No
is in	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpati	ent 2 ER/Outpatie	ent 3 DOA Other: 4[	☐ Nursing Home ₺ 🗖 R	esidence 6 Other (S	pecify)
After	ation:	27. Manner of Death  1 Natural 5 Pendir 2 Accident investi	gation	ery 28b. Time of Injury	of 28c. Injury at Work?  M 1 □ Yes	28d. Descri	be how injury occurred	
e Funeral Director: , letely filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined [20e. Place of In]	ury - At home, farm, st c. <i>(Specify)</i>	reet, factory, office		n (Street and Number or Town, State)	Rural Route Number,
y fill	Medical		ng Physician: To the best Examiner: On the basis of and manner st	of examination and/or in				
letel	4.							
To the Fun completely	Me	29b. Signature and title of certifie			29c. License num		29d. Date signed (Mo	
completel	Me	29b. Signature and title of certified  30. Name and address of person  Shawara MA						

DHMH 17 Rev 1/2001

	-	For State	State of Maryla	_				/	2008	27050
		Registrar			rtificate of I	Jealii 	2. Date of Dea	leg. No.		3. Time of Death
Physicia	an	Decedent's Name (First, Middle, Li		1111			Month	Day	Year	
/Medic		Irene	Catherine	Wineb		Location of Deat	August	16	2008 unty of Death	12:30P M
Examin	er	4a. Facility Name (If not institution, gr 400 Key High				timore	1	40.00	unty of Death	
Funeral				s. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	1 161		lace (State or Foreign
Director		212-03-9899	1□ M 2□ <b>X</b> F	Yrs.	Months Days	Hours Min.	Mar. 22	, <sup>1</sup> 91	9 Mary	Tand
p.		Usual Residence of Decedent							14	Od Incide Challingto
arytar show	_	10a. State 10b. County	10c. C	City, Town or L	ocation				'	0d. Inside City Limits 1 ☐ Yes 2 🕱 No
e Ma Ba-f	Director		erick		Union Br	idge		10 011	-61006-00	
Mith #		10e. Street and Number			10f. Zip Code			rog. Cilizer	of What Cour	
s 23	Funeral		n Valley Rd.	11.0 12	Was Decedent of H	21791	Specify Ves or No.	14	Race - Americ	
item item	E	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>	Armed Forces?	0.3.	If Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)	13.	Black, White,	
al", or	<u>\$</u>	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 No	Specify:		Sp	ecify: Whi	te
And I yill all a Lice Cooking the Maryland 2 should be filed within 72 hours after death with the Maryland namd Mental Hygiene. Its marked other than "natural", or items 23a or 28a-f show raumatic event, the Maryland Evention must be notified at	ted	15. Decedent's I (Specify only highest g	Education	16a. Dec	edent's Usual Occup	ation	rkina	16b. Kind	of Business/In	dustry
thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		e kind of work done DO NOT use retire		rking			
ed will ygien t, th	် ပ	12		0	wner/oper					ardware
be file tal H d oth	Be	17. Father's Name (First, Middle, Las	(t)				me (First, Middle,		rname)	
Lal y fail of Lal 2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Manage of the control of the manage of the control of the manage of	은	Leven Barnes					ida Bile			
VICAL 12 sh h and 7 is n traun		19a. Informant's Name/Relationship			ling Address (Street			-		o Code)
Te, Malyical yion 1916 stand 2 should if Health and Meritem 27 is marke other traumatic		Thomas W. Winebr			Box 362		n Bridge Date		tion - City or To	own, State
ages int of t: If it		1X Burial 2 ☐ Cremation 3	☐ Removal from State		osition (Name of ematory or other place	i	4 (0000		n • 1	110
artme artme ortan Injur		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Ltc	1110	<u>ountain</u>	View Cem 22. Name and Addre	ss of Facility Un	1/2008	Unio	n Bride	je, Mu
permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau		Manue 7	Knothus.		6 E. Broa		Union Br			791
		23a. Part 1. Enter the disease, or co	mplications that caused the de						115	Approximate Interval Between
Physician		shock, or heart failure. List onl Immediate Cause (Final	y one cause on each line.	· L	11	T			1	Onset and Death
/Medical		disease or condition resulting in death)	a.  Due to (or as a cons	equence of):						
Examiner		On a constitution that are a distinguished	, C	GVV	nec	AF				5425
₽ #	iner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	Due to (or as a cons	requence of):	1. 1.	, , , ,				
ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	С	Hy	perte	2				
cate be executed cate be executed physician and the burial-transit		rooding in doddin Edot	Due to (or as a cons	sequence on: {	,					
physi the t	dical		d					_		
eath certific attending p	/Me	IF FEMALE:	23c. If yes, outcome of preg	anancv				22	d. Date of deliv	von.
eath atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ F	etal death 3	☐ Ectopic pregnand	СУ		20	Month	Day Year
the d	Physician/Me	1 □Yes 2 □No 9 □ Unknown	9 ☐ Unknown		(				•	
s that	by Pi	Part II. Other significant conditions	contributing to death but not r	resulting in the	underlying cause giv	ven in Part I.	23e. Did t	obacco III e	contribute to	the cause of death?
v requires to the company of the com		1 Sin pe	Teroion	`			1 🗆 '	Yes 2	o 3□ Pro	bably 4 Unknown
as be	plet	<i>y</i>					24a. Was		24b. Were aut	opsy findings available ompletion of cause of
The The ate has	Completed							rmed?	death? 1 ☐ Yes	•
cian: T	Be C	25. Was case referred to medical examiner?				26. Place of De	eath (Check only o	ne)		
hysic this co	ဥ	1 Yes No		ER/Outpati	ent 3 L DOA		Home 5 ☐ Resi		Other (Spec	<sub>ify)</sub> Harbor
oding Phy th. : After thi e funeral o	ion:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year	28b. Time njury	Wo Wo		28d. Describe	how injury o	occurred	
Attend ar death ector: by the f	icat	2 Accident investigat 3 Suicide 6 Could not	ha	t hama farm a		Yes 2 □No	20f Location (	Ctunat and	Number of Du	ral Route Number,
or At after of Direction by	Certification:	4 ☐ Homicide determine	28e. Place of Injury - A building, etc. (Spe	ecify)	street, lactory, office		City or To	wn, State)	Number of mu	ar noble Number,
LIVISION OF VITAIL MECONDS, F. O. BOX 00/00, for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.		29a. Certifier Certifying	Physician: To the best of my	knowledge, de	ath occurred at the t	ime, date and pla	ce, and due to the	cause(s) a	and manner as	stated.
e Hos 24 h e Fur letely	Medical		aminer: On the basis of exam and manner stated.							
To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Me	29b. Signature and title of certifier			29¢/Licen	e number		29d. Date	signed (Month	, Day, Year)
		) you			1	105	30	(	5//	1/08
		30. Name and atidress of person wit	o completed cause of death (	Item 23a) (Type	e, Print)	~	, / ^	1000	rsna	TE, ME
		Jun Why	5, 10	V/V	Non	1),	UN	NOY	7-1	291
Sta Regist	ate	31. Date filed (Month, Day, Year) AUG 2 1 2	32 Registrar's Signal Registrar'	gnature	antil p					
riegist	2001	11000 1	State State of	The state of the s	all Base		_			

8-06232	Please Type or Print in Black Indelible	e Ink. Ensure All Copies Are Leg	ible.
	For State Certificate	It of Health and Mental Hygiene e of Death	.No. 2008 2705
Physician/ 1 Medical Examiner	egistrar . Decedent's Name (First, Middle,Last) JEANNETTE BARLOW WOOLLEY	HAN August 14,	Day Year 1200 hrs
4	a. Facility Name (if not institution, give street and number) 2732 Crystal Beach Road	4b. City, Town, or Location of Death  Earleville	4c. County of Death Cecil
i ulleral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthdi 221-16-2765 1 M 2 F 81	**	(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Delaware
fue we	Jsual Residence of Decedent  10a. State 10b. County 10c. City, Town or MD Cecil Earle  10e. Street and Number 2732 Crystal Beach Rd.	ville 10f. Zip Code 10	1 10d. Inside City Limits 1 Yes 2 No g. Citizen of What Country?
death with or items 23, must be not		3. Was Decedent of Hispanic Origin? ( Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Yes 2 X No specify:	U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: White
"natural"  Examing	15 Decedent's Education (Specify only highest grade completed) 16a. De	ecedent's Usual Occupation (Give kind of work done ring most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Baltimore, MD 21215-0036 gernit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", injury or other tranmatic event, the Me Heal Examiner.  To Be Completed by F	1 2 H	omemaker  18.Mother's Name (First, Middle, N	Own Home
21215 Uld be fill Mental E marked t event, t	Samuel Barlow  19a. Informant's Name/Relationship (Type, Print )  19b.	Julia Maul Mailing Address (Street and Number or Rural Route Num	nber, City or Town, State, Zip Code)
e, MD and 2 sho Health and item 27 is tranmati	Zoa. Wethou of Disposition	) 126 Boxwood Rd. Mid Disposition (Name of cemetery, yor other place)	dletown, DF. 19709
Baltimore, permit. Pages I a Department of He Important: If ite injury or other to	1 Bilinal 2 V Cremation 3 Removal Iron State I	Cremation 8/15/08	Smyrna, DE.
	M00510  Sea. Part I. Enter the disease, or complications that caused the death. Do not	<sup>22</sup> Name and Address of Facility Galena Funeral Home of 118 West Cross St. Ga	itelia, MD. 21033
Physician /Medical Examiner	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Between Onset and Death
executed an and al - transit	d		
ox 687 ath certific attending p or use as th	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 ✓ No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregnancy Other (Specify)	23d. Date of delivery Month Day Year
i, P.O. Be ires that the de signed by the be detached for the detached for the be detached for the bed by Physical by Physical for the forest for the forest	Part II. Other significant conditions contributing to death but not resulting	1Ye	obacco use contribute to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the representation and Director. After this certificate has been signed by the funeral director, page 2 should be detached in by the funeral director. To Be Completed by Perification: To Be Completed by Period.		1 Yes	
Vital Recysician: The his certificate director, page	25. Was case referred to medical examiner? Hospital:   Inpatient 2 ER/Ou	26.Place of Death (Check only one)  Itpatient 3 DOA Other Nursing Home 5	Residence 6 🗸 Other: Scene
n of Vinding Physical After this efuncal distribution: To	1 Yes 2 No	The second secon	how injury occurred
Division or pital or Attending ours after death. Girls Director After Girls Director After Girls of the fune Certification:	Suicide 6 Could not be determined (Specify)	rm, street, factory, office building, etc. 28f. Location or Town,	(Street and Number or Rural Route Number, City State)
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	one) 2 Medical Examiner: On the basis of examination and/or in	oth occurred at the time, date and place, and due to the cau avestigation, in my opinion, death occurred at the time, date	use(s) and manner as stated. e and place, and due to the cause(s)
To with To con	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year)  August 15, 2008
	30. Nale and podress of person who completed cause of death (Item 23a)  Pamela E. Sputhall, MD Assistant Medical Examine		
State Registrar	31. Date filed (Month, Day, Year)  32. Registrar's Signature	Spails .	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Phyllis Wright 15+ 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Plata If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 5, 1 Center Char Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 √2 F 040-24-3298 78 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No MD Charles Waldorf 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 1007 Stone Ave. 20602 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 □Yes 2 ☑ If Yes, Give 2 Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 No White Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Aide Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Ralph Wilson, Sr. Mary Farnham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharin Walker/Daughter 1007 Stone Ave. Waldorf.MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Brinsfield-Echols 8/16/2008 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 A Neme and Address of Figure FUNERAL HOME, P.A. M00945 qu Ehal 211 St. Mary's Ave. La Plata.MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metabolic Acidosis Due to (or as a consequence of): Democs Ranov Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of): 266212 Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ☐Yes 2 Mo 9 Unknown 23e. Did tobacco use contribate to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 Tyes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide determined

**Examiner** Division of Vital Records, P.O. Box 68760,

ttending physician and or use as the burial-tran ed by the detached cate has been signed by page 2 should be detack certificate

**Physician** 

/Medical

Examiner

Funeral

Director

show

Director

Funeral

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Completed

Be

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Physician/Medical

Completed

Be

Certification: To

Medical

7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be recilled at

Health and New 27 is mai

permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tr once.

Physician

/Medical

death with the Marylar

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate ba executed within 24 hours after death.

To tha Funeral Director: After this certific completely filled in by the funeral director, within 2

25. Was case referred to medical examiner? 27. Manner of Death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29a. Certifier

29c. License number

D002585

29d. Date signed (Month, Day, Year) 98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO 5 Garrett 92. Registrar's Signature AVE PO BOX 1070 La Plata MD 20646 31. Date filed (Month, Day, Year)

State Registrar

AUG 21



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			For State	State of Mary		Departmen <i>Certificat</i>			ental Hy	gien Reg. No	2000	27053
	-		Registrar  1. Decedent's Name (First, Middle,	Last)		Octimoat	C OI DCa		2. Date of De	eath	4000	3. Time of Death
	Physici /Medic		Kenneth	Collins	Winn,	Jr.			Quau:	st 12	2 2008	3 1715 M
	Examir		4a. Facility Name (If not institution,		1	4b. City,	Town, or Locat	tion of Death	J	40	. County of Deat	n •
	Funeral		The Memon 6 5. Social Security Number 6		n yrs. last bir	thday) If Under			8. Date of Bi	rth	Talbot	hplace (State or Foreign
	Director		231-44-3980	1x∏xM 2□F	70	Yrs. Months	Days Hou	urs Min.	July (	ay, rear 31, 1	1938 Vii	untry) Cginia
	and		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town	or Location						10d. Inside City Limits
	Maryl I-f sho	햧	Maryland		Coi	dova					į	1 □ Yes 2 □ No
	or 28s	Director	10e. Street and Number			10f. Zip	Code				itizen of What Co	
	sath w	eral	12325 Church	Lane	rinIIC	13 Was Doop	21625	o Origin? (Spe			ed State	es of Americ
50	r item r item iner	Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>	Armed Forces? 1 ☐ Yes 2 👿 No	r in 0.5.	13. Was Dece			Rican, etc.)		Black, White	
U)	hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be notified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes		ecify:				ıcasian
₩inn [ 21215-0036	n 72 h "natu kedica	Completed	15. Decedent's (Specify only highest	grade completed)	16a.	Oecedent's Usu (Give kind of wo life. DO NOT u	al Occupation rk done during se retired)	most of working	ng	16b. I	Kind of Business/	Industry
≥12	d withi giene.	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)	5	Self Em				Pa	inter/	Carpenter
ad C	be file tal Hy d othe event	Be	17. Father's Name (First, Middle, La	•			1	flother's Name				
ryla (	thould nd Mer marke matic	욘	Kenneth  19a. Informant's Name/Relationship		Jinn,			.,			eld Hav	
Senneth Caltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaniner must be notified at once.		Laura A. Win		1	•	*			-		and 21625
∩ ore,	jes 1 a t of He if item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐ Removal from State	20b. Place o cemete	Disposition (Natry, crematory or c	ne of ther place)	D	ate	20c. l	Location - City or	Town, State
E E	it. Pag rtment rtant: I njury o		4 Donation 5 □ Other (Spe	ecify)	Dente	on Ceme	tery		/2008	De	nton, l	Maryland
Bala	permi Depar Impor any ir		21. Signature of Funeral Service Li	Marke		Moore	Funer	raĺ Ho			Donton	21629 Maryland
			23a. Part 1. Enter the disease, or conshock, or heart failure. List or	omplications that caused the	e death. Do	not enter the mod	uth Sole of dying, suc	<mark>∋ c o n d</mark> ch as cardiac o	Stree r respiratory	arrest,	Denton	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_a 1504E1		ARDIO	UYOPA	THY				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a control of the second of the	onsequence	of): ENCE PE	14-60 6	ATHY	,			
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a c			., -0 .	,				
	ecuted and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с								
8760,	icate be executed physician and the burial-transit	al E	resulting in death) Last	Due to (or as a c	onsequence	01);						
687	or Attending Physician: The law requires that the death certificate be executed after death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	edical		d								
Вох	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 [	pregnancy Tetal death	a 3 ☐ Ectopic i	regnancy				23d. Date of de	livery Day Year
O.	he dea the at	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at tir 9 ☐ Unknown	ne of death	5 ☐ Other (s	pecify)				WOTH	Day 10 al
σ.	w requires that the destable is been signed by the should be detached		Part II. Other significant condition	s contributing to death but n	ot resulting i	n the underlying	ause given in F	Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ords	equires en sig ould be	Completed by							1 🗆	Yes	2 <b>X</b> No 3 □ P	robably 4 Unknown
ecc	iaw re has be	nplet							24a. Wa aut	opsy	24b. Were au	utopsy findings available completion of cause of
a H	sician: The law certificate has t irector, page 2 s			-,					1 □ Yes		death? lo 1 ☐ Yes	2.XNo
Division of Vital Records,	th. th. Tafter this certifica funeral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ※ No	Hospital:	2 ∏ ER/O	utpatient 3 □ D		Place of Death			6 □Other (Spe	scify)
n of	ng Phy fter thi neral (	on: T	27. Manner of Death 1 ▼Natural 5 □ Pending	28a. Date of Injury (Month, Day, Y	28b.	·	28c. Injury at Work?				ury occurred	
Siol	ttendil Jeath. tor: A the fu	icatio	2 Accident investiga 3 Suicide 6 Could no	Aha	At home for	M	1 ☐ Yes		20f Location	(Ctreet	and Mumbas as D	ural Route Number,
Divi	after of Direct of in by	ertif	4 ☐ Homicide determin	ed 28e. Place of Injury building, etc. (	Specify)	irm, street, ractor	, once	1	City or To			urar Houte Number,
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Medical Certification: To		Physician: To the best of r xaminer: On the basis of ex								
	the H hin 24 the F	Medi	one)	and manner stated			c. License num		ed at the time		Date signed (Mont	
	<b>6</b> × <b>6</b> 8	-	29b. Signature and title of certifier	4c1		23	D005				8-12-6	
			30. Name an address of person w	ho completed cause of deat	th (Item 23a)	(Type, Print)						
			John Botsis,			ington	Stree	t, Eas	ston,	Mar	yland	21601
7	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  AUG 1 4 200	32. Registrar's	Signature	Later .						
				The state of the s		ym						

**ORIGINAL** 

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8

27054

		1	For State Registrar	ate or mar	yiaiia / D	Certificate of E	Death	Reg.	No.	_ 100 .
	_		Decedent's Name (First, Middle, Last)			,		Date of Death     Month	Day Year	3. Time of Death
	Physicia		Daniel Joseph And	rvezak				August 18	,	9:45 PM
	/Medic Examin	_	la. Facility Name (If not institution, give stree			4b. City, Town, or			4c. County of Death	
	Examin	-1	1976 Guy Way			Dundalk			Baltimore	
	Funeral		5. Social Security Number 6. Sex	1	(In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ar) Coui	
	Director		218-28-5620 1XM	:UF .	75 <sup>Yı</sup>	rs.		January 1	, 193 3 Ma	aryland
	p.	-	Usual Residence of Decedent  10a, State 10b, County	1	I Oc. City, Town of	or Location				10d. Inside City Limits
	arylai shov	.	,	'	•					1 ∐Yes 2⊠No
	8a-f	Director	MD Baltimore		Dundall	10f. Zip Code		10g.	Citizen of What Cou	ntry?
	vith ti	吉	10e. Street and Number						USA	
	s 23	Funeral	1976 Guy Way	as Decedent Ev	er in U.S.	21222 13. Was Decedent of Hi If Yes, specity Cubar	spanic Origin? (Sp	ecify Yes or No-	14. Race - Ameri	
	item item	5	11. Iviantai Status	med Forces?				Rican, etc.)	Black, White,	etc.
38	be filed within 72 hours after death with the Maryland Hygiene.  d other than "natural", or items 23a or 28a-f show event, the Medical Evaning roust or notified at	۵		Yes, Give ear or Dates:		1 □Yes 2 🛛 No	Specify:		Specify: Wh	nite
ğ	2 hou	Completed	15. Decedent's Educatio	l Industrial	16a. l	Decedent's Usual Occupa	ation furing most of work		b. Kind of Business/Ir	ndustry
21215-0036	hin 7; e. an "n Medi	be	(Specify only highest grade con	ollege (1-4or 5+)	, '	Give kind of work done o life. DO NOT use retired	)			
2	d with giene	Ö	12		Med	chanic			Manufactu	ring
b	al Hy al Hy oth	Be (	17. Father's Name (First, Middle, Last)					e (First, Middle, Mai	iden Surname)	ļ
<u>a</u>	should b and Ment s marked umatic e	္	Adam Andryszak					Grabowski		(-0-10)
a.	2 sho n and is ma	A 7	19a. Informant's Name/Relationship (Type. I	rint)		Mailing Address (Street a				p Code)
≥,	and sealth n 27		2011211	on)		04 Holborn		dalk, MD.	c. Location - City or T	own, State
ore	pes 1 t of H If item		20a. Method of Disposition 1   ■ Burial 2 □ Cremation 3 □ Remo	al from State		Dispositi <i>o</i> n ( <i>Nam</i> e of , crematory or other plac	e)			
Ē	Pages ment of tant: If its lury or o		4 □ Donation 5 □ Other (Specify)		St. St	anislaus Ce	m. 08/2	1/2008	Baltimore,	Maryland Of Dundalk
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinations to unfilled at any injury or other traumatic event, the Medical Examinations to undified at ange.		21. Signature of Funeral Service Licensee	/ / /		1				Inc.
_			23a. Part 1 Enter the disease, or complication	al	h dos Don	7922 Wise		ndalk, MD.		Approximate Interval Between
			shock, or heart failure. List only one ca	use on each life	in dea . Do ii	or enter the mode of dym	ig, oud, as surand	- > _		Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	11	illes	()11	(h/)	<del>/-&gt;</del>		>14Cm
All	/Medical Examiner		resulting in doubly	Due to (or	consequence		1	811	-1	
		<u></u>	Sequentially list conditions,	Due to (or sea	Conse france o	09 0	OH C	us		
	rted nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Al Como					1	2
,	n and al-tra	Examiner	that initiated events c resulting in death) Last	Due to (or as a	consequence o	f):				
68760,	rificate be executed in physician and as the burial-transit		<b>L</b> d							
.89	tificat g phy as th	ledical								
Вох			23b. Was decedent pregnant	f yes, outcome o		3 ☐ Ectopic pregnanc	:v		23d. Date of deli	ivery Day Year
œ.	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	Physician/¶	in the past 12 months?	Pregnant at		5 Other (specify)			Worter	Day .ou.
P.O.	t the by th tache	hys	9 ☐ Unknown					22a Did taha	acco use contribute to	the cause of death?
	ss tha	by F	Part II. Other significant conditions contrib	iting to death bu	t not resulting in	the underlying cause giv	en in Part I.	1 ☐ Yes		
Š	equire en si ould b							1 163		
ပ္ပ	2 88 2	ple						24a. Was an autopsy	24b. Were au prior to	topsy findings available completion of cause of
Œ	The cate h	Completed						perform 1 □ Yes 2		; 2 □ No
ita	ician: The certificate ector, pag	Be (	25. Was case referred to medical examiner?			104		th (Check only one,	)	
Ž	ding Physician: h. After this certific funeral director,		1 Yes 2 No	1 ☐ Inpatier		tpatient 3 DOA Oth	4 🗀 Nursing r	lome 52 Resider	nce 6 Other (Spe	cify)
ם		ë	1 Z Natural 5 I toliding	8a. Date of Injur (Month, Day	y ; <i>Year)</i> 280. I	ime of 28c. Injury Wor	ryaτ 1k? ]Yes 2 ∐No	28d. Describe nov	Villiary occurred	
sio	Attending r death. ector: Afte by the fune	cati	2 ☐ Accident investigation	On Diago of Inju	n. At home far	rm, street, factory, office	1162 2 1140	28f. Location (Stre	eet and Number or Ri	ural Route Number,
Division of Vital Records,	l or Atten after deatl Director:	Certification: To	4 ☐ Homicide determined	building, etc	. (Specify)	m, street, lactory, office		City or Town,		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physici	n: To the best o	of my knowledge	, death occurred at the t	ime, date and plac	l e, and due to the ca	use(s) and manner a	s stated.
	24 hos 24 hos Fun etely	Medical	(Check only 2 Medical Examiner one)	On the basis of and mayiner sta	examination an	d/or investigation, in my	opinion, death occi	urred at the time, da	te and place, and due	to the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certifier	1/		29c. Licens	se number	29	d. Date signed (Mont	h, Day, Year)
	~~~		) / h	11	/	D	42736		7-19-	00
	, , , `		30. Name and addres of person woo con-	ed car se of de	eath (Item a)			Towso	mh	
	6+1	18	Ayman AKKA	M.	7400	Osler Di	~ #411	10 WS0	n, 11100	11204
		ate	31. Date filed (Month, Day, Year) 2008	32. Registra	ar's Signature	rente				
	Reaist	rar	THE PERSON NAMED IN		- 0					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 27055 State of Manyland / Department of Health and Mental Hydiana

lay	mond Alstor	1	- For State	te of Maryland / [	Department of Certificate of		Mental Hy		g. <b>N</b> o.	
	Physicia	an/	1. Decedent's Name (First, Middle,					2. Date of Death	n Year	3. Time of Death
	al Exami		Kaymond Et	agene Alg	ston, Dr.	b. City, Town, or L	ocation of Death	August 19,	4c. County of Deat	1413 hrs
			Johns Hopkins Hospital			Baltimore Cit				_
	Funeral		5. Social Security Number 6	. Sex 7. Age (I	In yrs. last birthday)	If Under 1 Year	If Under 24Hrs Hours Min.	_	h(MM/DD/YYYY) 9. Bii Forei	an l
	Director		00 201 1011	1 XiM 2 F	42 Yrs.	Months Days	Hours Min.	12/01	1965 c	ountry) MD
	any		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Location	on				10d. Inside City Limits
	* ·	_	MD		1	Baltimor	ישי			1 X Yes 2 No
5	Maryla 28a-f d at on	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?
1	215-0036  be filed within 72 hours after death with the Maryland ntal Hygiene.  rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.		2433 Prestor		· · · · · · · · · · · · · · · · · · ·	212		**************************************	USA	ion Indian Block
	ath wi	Funeral	11. Marital Status  1 Never Married 2 Mar	12. Was Decedent Ev	If Ye	Decedent of Hisp es, specify Cuban,			White, etc.	rican Indian, Black,
	ifter de		• •	1 Yes 2	1	Yes 2 X No	specify:		Specify: Bla	ack
	hours a	ed by	15. Decedent's Education (Specif		during me	's Usual Occupationst of working life. I			16b. Kind of Business	/Industry
	36 nin 72 than "	plet	Elementary/Secondary (0-12)	College (1-4 or 5+)		iborer			Warehou	150.
	5-0036 led within 72 Hygiene. other than '	Completed	17. Father's Name (First, Middle, L	ast)		11	8.Mother's Name	(First, Middle, M	Maiden Surname)	130
	21215-0036 vald be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be	Hubert Alst	on, Sc.	Lagrania		Christi		mbles	7:- 0-4-)
	O 4 5 5 5	٩	19a. Informant's Name/Relationshi	lount	243	3 Pres	01		altimac	
	re, MI s I and 2 s of Health a If item 27		20a. Method of Disposition		20b. Place of Disposi crematory or oth	tion (Name of cem	1411 - 11	Date	20c. Location - City o	
		11	1 Burial 2 X Cremation 4 Donation 5 Other Spe		Ardent	Cremat	ora 081.	25 2008	Hanover,	MD. A functal Sives
	Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other to		21. Signature of Funeral Service L		22. N	ame and Address	of Facility	Hip A.V	Veatherton	a funcial Sics
	Physician		23a. Part I. Enter the disease, or c	omplications that caused th	e death. Do not enter th	e mode of dying, s	iver of	or respiratory arre	Himore, Milest, shock, or heart	Approximate Interval
(	Medical		failure. List only one cause o  Immediate Cause (Final disease	n each line.	lerotic car					Between Onset and Death
	Éxaminer		or condition resulting in death)	Due to (or as a consequ		<del> </del>				
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	uence of):					
		Examine	cause. Enter Underlying Cause (Disease or injury that Initiated	c.  Due to (or as a consequ	uonaa aft:					
	uted Id ansit		events resulting in death) Last	d.						
	e exec cian ar irial - t	dica	X UNPENDED	X AMENDED #1,	23a,27,perl	Æ, g883	9/11/08	TT		
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome		al death 3	Ectopic pregna	ancy	23d. Date of delive Month	ry Day Year
	Box 687 death certificathe attending place as the	iciar	past 12 months?	4 Pregnant at tin	me of dooth	ner (Specify)			The table	
	. Bo he deat y the at hed fo	hys	1 Yes 2 No 9 Unkn	9 Olikilowii	out not reculting in the c	ndorlying agus a di	ivon in Part I	23e Did to	obacco use contribute t	o the cause of death?
	Division of Vital Records, P.O. B tall or Attending Physician: The law requires that the d attendent.  **All Directors**. After this certificate has been signed by the led in by the funeral director, page 2 should be detached	ক্র	Part II. Other significant conduct	ns contributing to death b	out not resulting in the t	ndenying cause gi	iveitiii Faiti.	5 cm		obably 4 🗸 Unknown
	ords, w require is been si should b	Completed						24a. Was autop		autopsy findings available completion of cause of
	ecol he law te has	dwc							rmed? death?	
	Vital Reccysician: The law	Be C	25. Was case referred to medical				of Death (Check	only one)		
	'Vita'	To E	examiner? 1 ✓ Yes 2 No		2 ER/Outpatient			-	Residence 6 Oth	er:
	n of ading P. h After e funera		27. Manner of Death  1 X Natural 5 Pendir	28a. Date of Injury (Month, Day,Yea	28b. Time of I		y at Work? es 2 No	280. Describe i	how injury occurred	
	r Atter r Atter er deat irector n by th	ficat	2 Accident Invest	igation	ry - At home, farm, stree	et, factory, office bu	uilding, etc.			Rural Route Number, City
	Division Hospital or Attent 24 hours after death Funeral Director: tely filled in by the	Certification:	Suicide 6 Could  4 Homicide determ		****			or Town, S	State)	
	Division of Nortending Ph To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral		29a. Certifier 1 Certifying Phyone) 2 Medical Exam	vsician: To the best of my kiner:On the basis of examin	knowledge, death occur	red at the time, da	te and place, and	d due to the caus	se(s) and manner as sta	ated. the cause(s)
	To the within 7 To the complet	Medical	29b. Signature and title of certifier	and manner stated.		29c. License			29d. Date signed (M	
			fanta.	1-11 1-11		O.C.N			August 20, 200	
	DY		30. Name and address of person v	who completed cause of dea						
	U		Pamela E. Southall, MI			1 Penn Street	, Baltimore, I	MD 21201		
	S	tate	31. Date filed (Month, Day, Year)	2. Registrar's	Signature 4					

ORIGINAL

DHMH 17 Rev 1/2001 **OCMF 2006** 

Registra

# Saltimore, Maryland 21215-0036

**Physician** /Medical **Examiner** Box 68760

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year Blackmon 12:28 AM 2008 Augus T /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner timore IF Under Social Security Number  $B_a$ of Mary 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, If Under 1 Year **Funeral** Hours Months Days 1 🗷 M 2 🗆 F Yrs reb 15,19 Director Durham, NC Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the "hydical Examiner" is ust be notified at 1 ☑ Yes 2 ☐ No Funeral Director WD timor 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 21206 ) verlea Dati 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 NYes 2 □ No Black, White, etc. 1 Mayes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced white n and Mental Hygiene. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Caltimore HD21206 Department of Health Important: If Item 27 i Jest Huenue Darlene lackmon 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens 21. Signature of Funeral Service Licensee Evans Fineral Chapel & Cremation 8800 Harford Rd Parkville MD 22. Name and Address of Facility Parkville MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 10 years Ischemic Heart disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Disease or injury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) signed by the a P.0. 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes Were autopsy findings available prior to completion of cause of death? autopsy performe 2 □ No 1 □ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1□Yes 2XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Esteban Galle 22 Green 5. 2. Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 21 State of Maryland Department of Health and Mental Hygiene 2 0 0 8 trar Certificate of Death Reg. No. For A State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 25, 2008 **Physician** 4:30 July **a.** M Cyrus L. Bailey /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Glider Middle River Baltimore Drive 8. Date of Birth (Month, Day, Year, 12/1930) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Social Security Number 6. Sex **Funeral** Months Days Hours 1 M 2 □ F 233-44-7900 78 **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at Baltimore MD Middle River 1 ☐ Yes 2 XNo Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21220 Glider Drive USA 4 ould be filed within 72 hours after death Mental Hygiene. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) 12th College (1-4or 5+) Owner Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter E. Bailey Minnie L. Lovelace 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mildred Bailey - Wife Glider Drive Baltimore, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Holly Hill Cemetery 07/29/2008 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex Christina Rolfes per dvr 300 Mace Ave., Balto., MD 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lung Cancer 3 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease 8 - 10 yrs. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Cardiomyopathy 8 yrs. Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Valvular Heart Disease 8 - 10 yrs. Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy use 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day for Month Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the 9 Hlnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ HTN, Renal Insufficiency, CVA 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes • No the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA thin 24 hours after this of the Funeral Director: After this of the Funeral filled in by the funeral directors. Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No M 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 Lane Mi) D57061 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohammad M. Rana, MD, 4920 Campbell Blvd., Baltimore, MD 21236 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 2 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008

			1 - State Amend 10f, perI	Nf G882 8/28	/08 g	Tificate of	Death	Reg	g. No.	2100.
	Dhusisi		Decedent's Name (First, Middle, Last)					Date of Death     Month	Day Year	3. Time of Death
	Physici /Medio			Norton Louis	se Be	arman				2:10P M
	Examir		4a. Facility Name (If not institution, give stree				r Location of Death		4c. County of Deatl	1
, e'			3004 Salisbury Ave		41-1-4-1				Balti	
	Funeral		5. Social Security Number 6. Sex 1 M	7. Age (In yrs. last 25t 5	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		nplace (State or Foreign untry)
	Director		Usual Residence of Decedent					Dec. 21,	,1912   Ma	ryland
	yland		10a. State 10b. County	10c. City, To	own or Lo	cation				10d. Inside City Limits
:	e Mar a-f sl	cto	Maryland Baltimo	re		Edgem	ere			1 □Yes XXNo
;	or 28	Director	10e. Street and Number			10f. Zip Code		10g	g. Citizen of What Co	untry?
,	ath w		3004 Salisbury Ave			21219	21222		United St	
	items	Funeral	11. Marital Status	/as Decedent Ever in U.S. rmed Forces? ∐Yes 2⊠No	13. \	Was Decedent of F f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	72 hours after death with the Maryland Inatural", or items 23a or 28a-f show dical Examinal must be notified at	by F	- Marie 11	∐ Yes 2 M No Yes, Give ear or Dates:		1 □Yes 2XINo	Specify:		Specify:	White
21215-0036	2 hou	ted	15. Decedent's Education	1 1	6a. Deced	dent's Usual Occup	pation	16	 6b. Kind of Business/l	
215	e. an "n	Completed	(Specify only highest grade con Elementary/Secondary (0-12)	ollege (1-4or 5+)	(Give life. L	kind of work done DO NOT use retired	during most of worki	ing		
2	/gien /gien er th	Ö	10 Years	anaga (t. tar a t)	Ho	memaker			Own Ho	me
nd	d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			
yla	ould Men Marke	၉	George A. Stump					Mary Keck		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inportant: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Mealical Examinat must be notified at once.		19a. Informant's Name/Relationship (Type. F Peggy J. Bearman (	Daughter)		ng Address <i>(Street</i> Salisbu:			City or Town, State, 2 Maryland	tip Code) 21219
Jre,	of Her		20a. Method of Disposition	20b. Place	of Dispo	sition (Name of natory or other place	ce) [	Date 20	c. Location - City or	Town, State
<u>يا</u>	Page nent ant: If ury o		1 □ Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)				Cem. 8/18	8/2008	Baltimore	, Maryland
Baltimore,	eparti eparti porti y inj		21. Signature / uneral Section to any e	11/11	22	Name and Addre	ss of Facility Ck Funera	l Home of	Dundalk,	Inc.
ш	<u> </u>		1 10 mm	me	<u> </u>	7922 Wi	se Ave.	Dundalk,	Maryland	21222
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the death. It use on each line.	o not ent	er the mode of dyir	ng, such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death
	hysician		Immediate Cause (Final disease or condition resulting in death)	Acut	e fu	Imona	Ry Ede	mA		hours
	/Medical Examiner		resulting in death)	Due to (or as a consequence	ce of):		dionyo	4		21-17
		-	Sequentially list conditions, if any leading to immediate	Due to (or as a consequent	cker ce of):	nic car	dione	palne		MONTHS
	ureu d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.							
o,	an an rial-tra	Exa	resulting in death) Last	Due to (or as a consequence	ce of):					
68760,	icate be executed physician and the burial-transit	Medical	d							
39	ing pl		IF FEMALE:				1100000		17/25 = -1	
Box	attendii for use	ian	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pregnancy Live birth 2 Fetal de	ath 3 □	Ectopic pregnanc	у		23d. Date of del Month	ivery Day Year
o }	w requires triat the ce been signed by the s should be detached t	Physician/	1 TVes 2 No. 4	☐ Pregnant at time of deatl ☐ Unknown	h 5L	Other (specify) _				
S, P.	gned I	by P	Part II. Other significant conditions contribu	ting to death but not resulting	g in the ur	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
g	equile		Amy DOD AN	aispathy w	ith	Deonen	STA	1 ☐ Yes	2 <b>√</b> 2 No 3 □ Pr	obably 4 Unknown
o i	has be	Completed		1 /				24a. Was an autopsy	24b. Were au	topsy findings evailable completion of cause of
		l m						performe	ed? death?	
/ita	ertific setor,	Be (	25. Was case referred to medical examiner?				26. Place of Death			
of o	this certificate ha	၉	1 Yes 2 No Hospi	1 ☐ Inpatient 2 ☐ ER/			4 🗀 Nursing Ho		ce 6 ☐ Other (Spec	cify)
Division of Vital Records,	After funer	tion	1 Natural 5 ☐ Pending	la. Date of Injury (Month, Day, Year)	b. Time of Injury	Wor	yat k? Yes 2 ∐No	28d. Describe how	injury occurred	
isi	deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be	e. Place of Injury - At home	farm, stre		100	28f. Location (Stre	eet and Number or Ru	ıral Route Number.
	a after	Certification: To	4 Homicide determined	building, etc. (Specify)				City or Town,	State)	,
y Division of Vita	within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral		29a. Certifier  (Check only  2 Medical Examiner:	n: To the best of my knowled	dge, death	occurred at the ti	me, date and place,	and due to the cau	use(s) and manner as	s stated.
1	in 24 the Fu	Medical	one)	On the basis of examination and manner stated.	and/or in	vestigation, in my o	opinion, death occuri	red at the time, dat	e and place, and due	to the cause(s)
	To To	Σ	29b. Signature and title of certifier	w- Ml.	18.10	29c. Licens	e number	290	d. Date signed (Monti	
	4			y Jattery	MNW	L	11115	1-	ruy 15,	2008
1	5		30. Name and address of person who complete Au Schwig		a) (Type, I	Print)	1600 /	21 21	712	
	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's Signature	7.	ieneu	with /	of est	-10	
	Registr	ar	31. Date filed (Month, Day, Year) AUG 2 2 2008	Home &	door	les .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** AUGUST 19, 2008 JOSEPH GILBERT BONNEY JR. 9:45 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1310 Scottsdale Drive Harford if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2 □ F Director 014-24-6505 75 May 17, 1933 Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical ExamIner must be notified at 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1310 Scottsdale Drive 21014 USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Tres 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Bowling Pro Shop 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Theresa Rich Joseph Gilbert Bonney Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Lois Bonney / Wife 1310 Scottsdale Drive, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Veteran Cem. 8-26-08 Crownsville, Maryland 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2√No 24a. Was an autopsy performed Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To

**Physician** /Medical Examiner Physician: The law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, physician

with the Maryland

death \

filed within 72 hours after

Peges 1 and 2 should be

21215-0036

aryland

Baltimore,

5

d

nse for signed by be detailed page 2 should funeral director, this After 1

or Attending

24 hours after death Funeral Director: filled in by

Hospital completely within 24 12+

Registrar

31. Date filed (Month, Day, Year) AUG 2 2 2008

29b. Signature and title of certifier

27. Manner of Death

1 Natural

2 ☐ Accident

4 Homicide

(Check only

3 ☐ Suicide

29a. Certifier

one)

5 Pending investigation

6 Could not be determined

 $\neg MD$ 2. Registrar's Signature

28a. Date of Injury (Month, Day Year)

and manner stated.

39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

\*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ∏Yes 2 ∏No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 2 7 1 5 1

			1 - State Registrar	Certificate of Death	Reg. N	10.							
	Discontact		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year 3. Time of Death								
	Physici /Medio		Vera L. Bownes		Aug 1								
an law.	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death							
			Union Memorial Hospital	Baltimore		N/A							
	Funeral Director		5. Social Security Number  218-58-5049  Usual Residence of Decedent  6. Sex 1 M 2 F 7. Age (In yrs. last birt.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 5 / 31 / 51	9. Birthplace (State or Foreign Country)  MD							
	land ow		10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits							
	Mary -f sh	ģ	MD N/A Baltime	ore		1 DXYes 2 □ No							
	the rough	ie	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Country?							
	h with	a D	4110 Kinsway	21206		USA							
	deat ems	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto R	cify Yes or No-	14. Race - American Indian, Black, White, etc.							
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examinar must be rediffied at once.	Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify. African American							
رب ا	72 h 'natu	ete	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	g 16b.	Kind of Business/Industry							
121	within ene. than	dm	Elementary/Secondary (0-12)   College (1-4or 5+)	Account Payable	T	Cowson State							
d 2	Hygie Ther int,	ပ္သ	12 17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maide	ien Surname)							
ä	ld be lental ked o	To Be	David Williams, Sr.		Bell Cra								
ary	shou and M s mar umat	-	19a. Informant's Name/Relationship (Type. Print)	Mailing Address (Street and Number or Rural	Route Number, City	y or Town, State, Zip Code)							
Σ	and 2		Referra Bennes, Sangree	110 Kinsway, Balt:		ID 21206							
Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 20b. Place of cemetage.	Disposition (Name of y, crematory or other place)  ew Crematory 8/26	te 20c.	Location - City or Town, State Limore, MD							
Ë	. Pag tment tant: jury c		4 □ Donation										
3alt	permit Depar Impor any In		21. Signature of Fun ral Service Licerum	22. Name and Address of Facility Har: 5126 Belair Rd.,	i P. Clo	Sse F Svs APA							
			220 Part 1 Sept the diagram or complications that accord the death. Do n	·									
			23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final										
Serve of	hysician /Medical		influence coalse in many disease or condition resulting in death)  a. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										
	Examiner		Chamil Obstraction Only and Dr. College 102 4 ports										
,		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	of):	9 11.3	10 7 Pars							
	eath certificate be executed attending physician and for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events										
90	De execian a		resulting in death) Last  Due to (or as a consequence or	rf):									
68760,	cate t	Medical	d										
9 ×	ding ding se as		IF FEMALE: 23c. If yes, outcome of pregnancy										
Вох	atter for u	cian	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery  Month Day Year							
P. O.	that the de ned by the a detached f	Physician	1   Yes 2 PNo 9   Unknown	one (openly)									
<u>.                                    </u>	s that ned t	by Pi	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?							
ğ	w requires that s been signed t should be dete	g pe			1 ☐ Yes	2 No 3 Probably 4 Onknown							
ည္က မ	e faw re has bee	Completed			24a. Was an	24b. Were autopsy findings available prior to completion of cause of							
Ě	The I	E O	autopsy prior to performed? death?  1 □ Yes 2 □ No 1 □ Yes										
ita	ilclan: The certificate rector, pag	Bec	25. Was case referred to medical examiner?										
<u></u>	Physic this co		Hospital:	tpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom	e 5 Residence	6 ☐ Other (Specify)							
Ē	tending Physician: The leath.  Ior. After this certificate hathe funeral director, page	ö	27. Manner of Death 28a. Date of Injury 28b. Ti 1 □ Natural 5 □ Pending (Month, Day, Year) In	njury Work?	8d. Describe how in	jury occurred							
Si Si	tend leath tor: / the f	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of Injury. At home for	M 1 □Yes 2 □No									
Division of Vital Records,	or Al after of Direction by	Certification: To	4 ☐ Homicide	m, street, ractory, office	City or Town, St	and Number or Rural Route Number, ate)							
	spital		29a. Certifier 1 Certifying Physician: To the best of my knowledge,	, death occurred at the time, date and place, a	nd due to the cause	e(s) and manner as stated.							
	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.	d/or investigation, in my opinion, death occurre	d at the time, date a	and place, and due to the cause(s)							
	Vithii Vomp Comp	M	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month, Day, Year)							
			Waleed Isolad M.	D. AT243894	6 A	ugust 19th 2008							
	5		30. Name and address of person who completed cause of death (Item 23a) (	Type, Print)									
	Ch		WALEED BOLAD M.P.  31. Date filed (Month, Day, Year)  32. Segistrar's Signature	, UNION ME	MORIAI	L HOSPITAL, MO							
	Sta Registr		AUG 2 2 2008 Areas &	Snarte !									
			1,-55-55	A STORY									

27062 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Coomes 7:32AM Brenda Marlene 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** How ford County Sable wood Road Bel Apt c If Under 1 Year | If Under 24 Hrs. | Months | Davs | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Days 217-60-0445 1953 **Director** August 30 Martland Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan 28a-f show Bel Air 1 ☐ Yes 2 No Director Harford County Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21014 United States Sablewood Apr Funeral or items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 K If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: þ Specify: White 3 Widowed 4 ☐ Divorced than "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled unemplayed N/A 19 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other i any Injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Gordon Burris Minnie Lewis ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bonnie Sue Burchett 208 Mc Glothlin Rd, Conoringo, Maryland 21918 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖫 Cremation 3 ☐ Removal from State Forest Hill, Mar-Iland A-5 14, 2005 Funeral chapel 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee =22. Name and Address of Facility and Cremation Services - Bel Air Jezn com ( MARTIANE 21050 Newport Drive, Forest 1511 23a. Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physiclan** Due to (or as a consiquence of): 2 NUG disease or condition resulting in death) /Medical 2- Notes 5413 Examiner Due to (or as a nonsequence of) Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2. No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. le Funeral Director: A bletely filled in by the fu investigation 2 Accident Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 23354 MA 1314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 22 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-06218 27063 2008 State of Maryland / Department of Health and Mental Hygiene Lonnie Dean Campbell Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day August 14, 2008 Physician/ 0915 hrs Medical Examiner LOnnie Dean Campbell

4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Baltimore County** rear of 1601 Old Eastern Avenue 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. If Under 1 Year Age (In yrs. last birthday) Social Security Number **Funeral** Davs Hours Months Maryland Director 2/03/1953 213-62-3088 1 X M 2 54 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 X No or items 23a or 28a-f show must be notified at once. MD Baltimore Dunda1k Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f cho Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8214 Road 21222 U.S.A. Kavanagh 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married Armed Forces? Married Yes Specify: Yes 2 X No specify. White If Yes, Give Year Divorced Widowed event, the Medical Examiner ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) UNK. during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) The1ma J. Prettyman Campbell Eugene å 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) or other traumatic 101 Stephanie Court Rising Sun, Maryland Lawrence Campbell/ Brother Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Baltimore, 2 Cremation 3 Removal from State 8/18/08 Elkridge, Maryland Meadowridge Mem. Park mportant Donation 5 Other Specify: 22. Name and Address of Facility Duda-Ruck F.H. of Dundalk, Inc. 21. Signature of Funeral Service Licenses 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line. Death /Medical a Dilated cardiomegaly Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed AMENDED 23a, PII, 27, per ME g883 9/24/08 TT Physician/Medical X UNPENDED attending physician for use as the burial 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Day 3b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth this certificate has been signed by the attending director, page 2 should be detached for use as it past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö 1 Yes 2 No 3 Probably 4 V Unknown ξ Chronic alcohol use Division of Vital Records, P. Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 ✔ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> Residence 6 V Other: Scene Hospital: 1 Nursing Home 5 ER/Outpatient 3 DOA 2 Inpatient 1 ✔ Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Dey, Year) 28b. Time of Injury After Manner of Death Certification: 1 X Natural 1 Yes 2 5 Pending 24 hours after death Funeral Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely Medical To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 15, 2008 O.C.M.E. -1410 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD Assistant Medical Examiner 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2308 Registrar

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8-06254

2008 27064

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ucinda Coleman. Certificate of Death 1- For State Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day August 15, 2008 Physician/ 0943 hrs Medical Examiner Lucinda Kay Coleman 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Cecil 6 Walden Court 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. Age (In yrs. last birthday) 6. Sex 5. Social Security Number oreign **Funeral** Hours Months Days Country) Maryland Director 214-98-3180 Yrs 42 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State Yes 2 XNo North East Maryland Cecil permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I filem 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at owner. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21901 6 Walden Court 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No 12. Was Decedent Ever in U.S Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married 2 X Married 2 X No Yes Specify: White 1 Yes 2 X No specify: Divorced If Yes, Give Year Widowed 16b. Kind of Business/Industry ۵ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 U.S. Government Bookkeeper 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) <u>Oleita Hulda Bowers</u> Be Larry Leon Barber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 6 Walden Court, North East, MD 21901 Doyle L. Coleman / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, permit Pages I and Department of Heal crematory or other place) 2 Cremation 3 Removal from State 1 X Burial 8-19-08 Bel Air, Maryland Bel Air Memorial Gdn. 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
McComas Funeral Home, P.A.

1317 Cokesbury Rd. Abingdon, MD 2

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Donation 5 Other Specify: MD 21009 Approximate interval Between Onset and **Physician** failure. List only one cause on each line. Death **Medical** Arrythmia Cardiac Immediate Cause (Final disease ∡amine: or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit 23a,27 per me g884 10-17-08 vt sician/Medical **AMENDED** X UNPENDED The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Day 3 Ectopic pregnancy Month 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 V No 3 Probably 4 Unknown ğ σ. 24b. Were autopsy findings available Completed 24a. Was an Records, prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✔ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Other of Vital Be Nursing Home 5 Residence 6 ✔ Other: Scene Hospital: examiner? ER/Outpatient 3 Inpatient this 1 Yes 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification Yes 2 No 1 X Natural Pending Division Director: hours after death. Investigation 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 6 Could not be Suicide determined Fo the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 16, 2008 O.C.M.E. )Monte 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Margarita Korell MD.

**OCME 2006** 

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32. Registrar's Signature

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AMEND ITEM#20b, perfff, G883, 9/8/08, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 200 cobert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Randallstown Kandallstown MOSIS If Under 1 Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) **Funeral** Vear Hours 1 M 2 □ F Director 219-30-2899 MD Usual Residence of Decedent 10d. Inside City Limits r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 1 XYes 2 No Completed by Funeral Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with "natural", or Items 23a or adical Examiner must be r USA 3008 Milford Avenue 21207 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Unk. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, the Medical al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Carr-bowery blass Co. Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental H To Be Lda *uacne* 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3008 Milford Avenue item 27 is Gladys Col-20a. Method of Disposition Cole Balfingere, MD, 2120
20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) **→** 1 N Burial 2 □ Cremation 3 □ Removal from State ò Department of Important: If any Injury or once. 8/30/08 Arbutus Mem. Pk. Baltimore, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Phillip A. Weartherford Funeral Street 21. Signature of Funeral Service License Baltimore, MD. 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Carker Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duri to for es a consequence of Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 0 NO 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1□ Yes 2□No Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 1 | Yes 2 | 1 | Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 5 ☐ Pending investigation 1 4 Matural Injury 1 ☐ Yes 2 □ No 2 Accident after death 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ò within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Offeck only 🛮 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner the 29d. Date signed (Month, Day, Year) Signature and title of certifier 291 29c. License number DOO 30. Name and address person who compl 32 Registrar's 31. Date filed (Mont 21133 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1836 PM Day Year Month **Physician** 200 8 8 Nancy Martha 20 Davis /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rosedale Baltimore CENTER FRANKLIN SQUARE HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/29/1942 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🛛 🛣 Maryland 66 213-38-9892 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2XXXII Director Baltimore Maryland Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Mydical Examiner must be some. U.S.A. 21221 929 Barron Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐Ho If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2€No Specify: Specify: White à 3 XXVidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital 12 Sterile Processor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Criddle Edison Hobbs ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7706 Fairgreen Road, Baltimore, Maryland 21222 John Myers (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ★ remation 3 ☐ Removal from State Bayview Crematory, INc. 08/25/2008 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 ig ... eral Service Licensee 23a. Parr. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 days Imprediate Cause (Final di ease or conuncesulting in death) Preumonia ease or condition Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Spinal abscess, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an Sacral

**Physician** /Medical Examiner or Attending Physician: The law requires that the death certificate be executed

show

ral", or items 23a or 28a-f shov Examiner must be redified at

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

Davis

and burial-t ing physician a as the burialcate has been signed by the a page 2 should be detached to After this

Certification: To Be ours after death.

neral Director: A

autopsy performed? 26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

m d

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death

5 Pending investigation 6 Could not be determined

1 Inpatient 28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

Medical

State Registrar 1 Natural

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

RES 0000

DR. Balto

-20-2008

21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANKLIN SQUARE 9000 DR Lee LIN

Hospital

31. Date filed (Month, Day, Year)

2008



NO

To the Hospital of within 24 hours a To the Funeral D the Hospital

completely

		For State	State	of Marylar			t of Hea e of Dea		lental Hy		200	0 2700	
Di		Registrar     Decedent's Name (First, Middle)	Last)		061	imeat	C OI DC	atri	2. Date of Do	Reg. No.	Year	3. Time of Death	
Physici /Medic		Edwin I							August	20,		8:07 A. <sup>M</sup>	
Examin	er	4a. Facility Name (If not institution, Stella Maris	give street and nu	ımber)			inoniu	ation of Death in			Baltinx		
Funeral Director			6. Sex <b>½</b> M 2□ F	7. Age (In yrs.		If Under Months	1 Year If U	Under 24 Hrs. ours Min.	8. Date of Bi (Month, D June 4	rth av. Yea <i>r</i> )	9. Birt	hplace (State or Foreign untry) ., Maryland	
70		Usual Residence of Decedent		100 0	ty, Town or Lo	cation						10d. Inside City Limits	
farylar show	or	10a. State 10b. County  Maryland Harfo	ord		Monktor							1 □ Yes 2 No	
the N 28a-1 notifi	rect	10e. Street and Number				10f. Zip	Code				en of What Co		
th with 23a or 1st be	al D	3610 My Ladys V	Jiew Cour	t			21111			of	ted Sta America	ž	
should be filed within 72 hours after death with the Maryland and Mental Hygiene. The Maryland marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show matic event, the Madical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married XX Marri 3 □ Widowed 4 □ Divorced	Armed F	2 □ No live		Was Dece If Yes, spe 1 ☐ Yes		nic Origin? (Sp lexican, Puerto pecify:	pecify Yes or N Rican, etc.)		4. Race - Ame Black, Whit Specify: W	e, etc.	
d within 72 hours af giene. rr than "natural", or the Medical Exami	Completed b	15. Decedent (Specify only highes  Elementary/Secondary (0-12)	16a. Deced (Give life.	dent's Usu kind of wo DO NOT u	al Occupation rk done durin se retired)	n ng most of work	king	16b. Kir	nd of Business	/Industry			
d with	Som	12	College	(1-4or 5+) 4	Acc	count						rporation	
be deve	Be	17. Father's Name (First, Middle, I William Jame		<b>.</b>			18.	Mother's Nam Anna S	e (First, Middle Sauer	e, Maiden	Surname)		
s 1 and 2 should be f Health and Mental Item 27 Is marked o other traumatic eve	유	19a. Informant's Name/Relationsh	ng Address	(Street and			ber, City or	Town, State,	Zip Code) 21093				
nd 2 s The ar 27 Is	l j	Dr. Eric Donoho										aryland	
00		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from	20b.	Place of Dispo cemetery, crei ans Fun	osition (Na	me of other place)	Augu	Date 1St		cation - City or	· —	
Title Pa		4 □ Donation 5 □ Other (S)	pecify)	Č	hapel-	Bel	Air	22,	2008	l		ill, Marylar	
permit. Departn Importa any Inju	k) 5	21. Signature of Funeral Service	Sill	A.	Pé	2325	ul Alt York	ernativ Road T	ves Fun Timoniu	eral M, Ma	&Cremat ryland	ion Ctr.,P. 21093	
Physician Medical Examiner		Onset and disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):									Interval Between Onset and Death		
icate be executed physician and the bunal-transit	dical Examiner												
death certifi e attending l d for use as	Physician/Medi	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	⊒Ectopic p ⊒ Other (s				23d. Date of delivery Month Day Year						
w requires that is been signed by should be detail	by	Part II. Other significant condition	ons contributing to	underlying	cause given ir	Part I.		id tobacco use contribute to the cause of death? □ Yes 2 ☑ No 3 □ Probably 4 □Unknown					
sician: The law requires that the certificate has been signed by the rector, page 2 should be detached.	Completed							prior to completion of ca					
cian: ertifica	Be C	25. Was case referred to medical examiner?						3. Place of Dea	ath (Check only	one)			
Physi this c	은	1 ☐ Yes 2 ☐ No 27. Manner of Death		Inpatient 2	ER/Outpatie				lome 5 ☐ Re			ecify)	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, p	Certification:	1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could in	M treet, facto		2 □ No	28f. Location	3d. Describe how injury occurred 3f. Location (Street and Number or Rural Route Number,						
spital or /		29a. Certifier 1 Certifyir	ng Physician: To t		nowledge, dea				e, and due to th		and manner a		
n 24 h n 24 h ne Fur	Medical	(Check only 2 Medical one)	Examiner: On the and ma	basis of examir anner stated.	nation and/or in	nvestigatio	n, in my opini	on, death occu	urred at the tim	e, date and	d place, and du	ue to the cause(s)	
	Me	29b. Signature and title of certifie	Mons	mo	2	25	Oc. License nu クプマタ	umber		29d. Date signed (Month, Day, Year)  8/21/200  Peroform, form, MS 2113			
111		30. Name and address of person	who completed ca	use of death (Ite	em 23a) (Type	, Print)	igh-	D	. R	e.>/-	1,400	, ml 2113	
Sta	ate	31. Date filed (Month, Day Year)	2 2008 32	edistrar's Sign	nat we	A STATE OF THE PARTY OF THE PAR							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2, Date of Death Physician August 19°, 2008° 12:18 P.M Joseph David Douglas /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Timonium Baltimore County Stella Maris Hospice | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Fore Months Days Hours Min. | March 09,1921 | Balunore, MD. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex\_ 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Months 87 216-12-7658 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examples of the Medical Ex 1 ☐ Yes 2 No Director Maryland Baltimore County Timonium 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21093 2411 Chetwood Circle United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ZNes 2 □ No If Yes, Give W•W•II Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 HNo Specify: White 3 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Actuary State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) David Gray Douglas Mary Ann Lillvik 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary (nee Dugan) Douglas (Wife) Timonium, Maryland 21093 2411 Chetwood Circle August 2008 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 22, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland Dulaney Valley Mem. 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility acceful Alternatives Funeral & Cremation Ctr., P.A. 325 York Road Timonium, Maryland 21093 NEuneral Service Licenses Approximate Interval Between Onset and Death Farth. Interine discree, or camplications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory errest and ck, in his rutialiste. List only one cause on each line. Immediate Cau e (Final **Physician** CEREBROVASCULAR ACCIDENT disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine and that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year signed by the a 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 X No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \mathbf{X}$  Other (Specify) **HOSPICE** 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe 0/48 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

DR. TARIQ MAHMOOD

AUG 2

31. Date filed (Month, Day, Year)

JOSEPH DOUGLAS

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Maryland /	•	ate of Death		Reg. No.	2008	27069
П	Physicia		1. Decedent's Name (First, Middle, Last)	Diaas			_ M	ate of Death onth Day	Year 7008	3. Time of Death  5:54 PM
e silve	/Medic Examin		4a. Facility Name (If not institution, give s		4b. C	ty, Town, or Location		4c.	County of Death	NA
-	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	oirthday) If Un Monti		r 24 Hrs. 8. D.	ate of Birth fonth, Day, Year)	Cou	place (State or Foreign ntry)
	Director		317-66-6849 Usual Residence of Decedent	52			1-7	XII a) 15.		10d. Inside City Limits
	show	2	10a. State 10b. County N	10c. City, To	wn or Location	- 11: 12-0	.00			1 tes 2 No
	the M	Director	10e. Street and Number		10f.	Zip Code	3/6	10g. Cit	zen of What Cou	ntry?
	th with	ral D	3324 Garris	on Ave		2121	5		USA	
36	be filed within 72 hours after death with the Maryland ttal Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Experience must be profiled at	y Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Devorced	2. Was Decedent Ever in U.S. Armed Forces? 1 —Yes 2 [] No If Yes, Give Ye ar or Dates:		cedent of Hispanic O pecify Cuban, Mexica 2 TING Specify		es or No- , etc.)	14. Race - Amer Black, White, Specify:	
215-0036	72 hour 'natural' dical Ex	Completed by	15. Decedent's Edu (Specify only highest grade		Sa. Decedent's U	Isual Occupation work done during mo T use retired)	st of working	16b. K	nd of Business/li	ndustry
2121	filed within 72 Hygiene. vther than "nat ent, the Medic	Sompl	Elementary/Secondary (0-12)	College (1-4or 5+)	^	truction	Wor	Ker C	mstruc	tion
	ould be filed of Mental Hyginarked other artic event, It	Be	17. Father's Name (First, Middle, Last)			C 1	1	st, Middle, Maiden		
Maryland	E B B E	욘	19a. Informant's Name/Relationship (Ty	pe. Print)	9b. Mailing Add	ess (Street and Numi	enet ber or Rural Ro		r Town, State, Z	
-	and 2 sealth ar		Gloria Brisco		1176 (	resther		Rd Ba	ocation - City or 7	D21215
altimore,	Pages 1 and nent of Heali int: If item 2 iry or other		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	of Disposition ( etery, crematory	or other place)	8-23		Himore	mD
Balti	permit. Pag Department Important: I any injury o		21. Signature of Fund al Service Licens		22. Nam	and Address of Faci		h F/H	270174	chilten Fiss 3) MD 21229
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused the death. D			as cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death
đ	Physician		Immedia Cause (Final disease r condition resulting in death)	PHEUMON	IA					3 DAYS
T	/Medical Examiner			Due to (or as a consequence		IER DIS	SEAS	5		SVEARS.
7	ed it	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	ce of):	WHA! OF	21-1	1		SDAIC
√,0	icate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence		PHALOR	FULL	1		SD-145
68760,	tificate b ng physic as the bu	edical	•	l						
Box	eath cer attendir for use	Physician/Me	in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 ☐ Ecto	pic pregnancy r (specify)			23d. Date of del Month	ivery Day Year
P.0	w requires that the d been signed by the should be detached		9 ☐ Unknown  Part II. Other significant conditions co		g in the underlyi	ng cause given in Par	rti.	23e. Did tobacco	use contribute to	the cause of death?
rds,	quires en sign uld be	ed by					<u>\</u>	1 □ Yes 2	□No 3□Pi	obably 4 Unknown
Records,	The law relete has bee	Completed by						24a. Was an autopsy performed? 1 □ Yes 2 □ N	prior to death?	utopsy findings available completion of cause of
Vital	ysiclan: The is certificate hidirector, page	BeC	25. Was case referred to medical examiner?	12-6			ace of Death (C			
of\	ing Physi n. After this c funeral dire		1 Yes 25 No 27. Manner of Death		b. Time of	DOA Other: 4   28c. Injury at Work?		5 Residence Describe how inju		ecify)
ion	Attending r death. ector: After by the fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Đay, Year)	Injury M	1 □ Yes 21				
Division of	l or Atte after de Directo	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, fa	ctory, office	28f.	Location (Street a City or Town, Sta		ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)  Check only Medical Exam	sician: To the best of my knowle iner: On the basis of examination and manner stated.	edge, death occu n and/or investig	irred at the time, date ation, in my opinion, c	e and place, and death occurred a	due to the cause at the time, date a	s) and manner and place, and du	s stated. e to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of ce tifier			29c. License numbe	er	29d. D	ate signed (Mon	th, Day, Year)
			100		D.	AT-2438	946	Au	Gust 1	9,2008
	7		30. Name and address of person who of	ompleted cause of death (Item 23)  ONION  See Registrar's Signature	oa) (Type, Print)	ZIAL HOSP	TAL,	BALTIM	ORE N	PARYLAND.
	St Regist	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signature	A STATE OF THE PARTY OF THE PAR			_		/

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			1. Decedent's Nam	e (First, Middle,	Last)	_		inouto		700.077	2. Dete of De	ath		3. Time	of Death	
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*5	/Medic Examin			I not institution,	give street and num	ber)	174 4	-101	41	b. City, Town, or Lo						
4	Examin	31	OVEDI	הא מביאות	H & REHAI	יעבעב בעב	TITON			BALTIMOF	RE:					
-	Funeral		5. Social Security N		. Sex 7		last birthday)	If Under 1 \	rear Deys	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th v. Yeer)	9. Birthpl	ace (State	e or Foreign	
	Director		202-05-12 Usuef Residence of		1MM 2□ F	95	Yrs.	Months	Abys	Hours Will.		1913				
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at		10a. Stete	10b. County		10c. Ci	ty, Town or Lo	cation					10		City Limits	
	Mar.	ţ	Maryland	Harford	ł	Be.	l Air							1 SX Ye	es 2□No	
	4 28 E	S S	10e. Street end Nu	mber				10f. Zip Co	ode			10g. Citizen of V	Vhet Coun	ry?		
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	eep .	iner	11. Maritel Status		12. Was Deced	lent Ever in U es?	J,S. 13.	Was Deceden f Yes, specify	t of His Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Rac Blac	e - America ck, White, e			
20	s 1 and 2 should be filed within 72 hours after death with the Marylar f Haalth and Mental Hygiene. It has the same 23e or 28e-f show then 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Examiner must be notified at	Y F		ied 2 Married	If Yes, Give		1 ☐ Yes 2 ☑ No Specify:					/: T/	7-1			
21215-0020	hour land	었	3 🔀 Widowed	15. Decedent's	Year or Dat	es:					-	16b. Kind of Bu		hite		
15	n 72	lete		cify only highest	grade completed)		16e. Decedent's Usual Occupetion (Give kind of work done during most of wo life. DO NOT use retired)			luring most of work	aing		,			
12	with than	Completed by Funeral Director	Elemente ry/Seco	ondary (0-12) 12	College (1-	4or 5+)	Military Ba					U.S. G	overr	ment		
	filed Hygi other ent, ti	Be C	17. Fether's Neme		st)	18. Mother's Name					e (First, Middle					
<u>a</u>	ould be filed Mental Hygi arked other atic event, I	ToB	Howard	E. Drash	er						atherine Stout					
Maryland	2 should and Men is marke aumetic		19a. Informant's N				19b. Maili	ng Address (S	Street a	and Number or Rur	Rurel Route Number, City or Town, State, Zip Code)					
	1 and 2 Haalth a		Hannah E. Wheeling / Daughter 207 Courtland Place, Bel Air, MD 21014										014			
Baltimore,	a 0		20a. Method of Disposition  20b. Place of Disposition (Neme of cemetery, crematory or other place)  20c. Location - City or cemetery, crematory or other place)										City or To	wn, State		
Ĕ	Pages nent of ant: If its ury or o		4 Donetion 5 Other (Specify)  Mountain View Cemetery 8-22-08 Hazelton, Pennsylvania  21. Signature of Funeral Service Licensee  22. Name and Address of Fecility  Moccomes Funeral Home, P.A.												lvania	
a	permit. Page Department o Important: If i any injury or once.															
<u>m</u>	89 5 8	-1	1 Cha	on Un	I Gen !	-1				sbury Roa	and the last		D 210	09		
	77.74.20		23a. Part1. Enter t	he disease, or co	omplications It at cally one causal ee	sed the dear	th. Do not ent	er the mode o	of dying	, such as cardiac	or respiratory a	rrest,		Approxim	Between	
No.	Physician		SHOOK, OF HOE	in railbro. Elst of		0		01		11	11	9	1	Onset an	nd Death	
7	/Medical		Immediate Cause disease or condition	(Final	a	1107	uc.	rie	W	ale	ffu	210n				
100	Examiner		resulting in deeth)		1	Due to	or as a conse	quence of):	7	00 /	1//)					
	p #	lue			• h A	2he	sine	YS )	1	men	ma	•				
	cate be executed physician and ; the burial-transit	Examiner	Sequentially list co	nditions,	11	Due to (	or as a consec	uence of	'				1			
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O.	0 0 0	Physician/M	Part If. Other signif	ficant conditions	contributing to dea	ith but not res	sulting in the u	nderlying cau:	se give	en in Pert I.		Yes 2 No	3 Perol		l □ Unknown	
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ds,	requires that tha been signed by the hould be datache	d by										an autopsy		ere autops ailable pri	sy findings	
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Record	The law ate has b page 2 s	Completed									417	Yas 2XIII	1[	]Yes 2	2 No	
a	ysician: The l s cartificate he director, page		25. Was case refer	red termedical		26. Place of Death (Check only one)										
Vital	Physician: this cartific ral director,	o Be	examiner?		Hospitel: 1 D In	Othor						Home 5 ☐ Residence 6 ☐ Other (Specify)				
of	£ £ 5	$\vdash_{\mathbb{R}_{2}}$	27. Manner of Deat	th	28a. Dete of	Injury	28b. Time o		. Injury Worl			how injury occur				
<u>o</u>	nding Ph th. : After th e funeral	흹	1 Natural 2 Accident	5 Pending investige		, Dey Year)	Injury	М		Yes 2 □ No						
Division	or Attending after death. Director: Afte I in by the fune	<u>ا ت</u>	3 Suicide	6 Could no determine	art 200. Piece		nome, farm, st	reet, factory, o	office		28f. Location	(Street and Num own, State)	ber or Rura	I Route N	lumber,	
Ö		Certification:	4  Homicide		buildin	g, etc. (Speci	uy)				Ony or To	, 0.0.0/				
	Hospital 24 hours a Funeral l	ğ	29a. Certifier	Sortifying	Physician: To the b	est of my kn	owledge, deet	h occurred at	the tim	ne, date end place,	, end due to the	ceuse(s) and m	anner as s	tated.	se(s)	
	o the Hospital or vithin 24 hours after o the Funeral Dir completely filled in	edical	(Check only one)	⊯ Medical Ex	amfner: On the bas end mann		arion aud/or, iu	vestigation, in	my of	Jiriioti, death occul	neu at the time					
_	Vithin 2 To the Comple	Σ	29b. Signature and	title of certifier				29c. L	icense	number	01	29d. Date signe	ed (Month,	Day, Yea.	00	

5+1

State Registrar

32. Registrer's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** HAYWOOD 8-19-2008 9:50 A M GREEN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY Birthplace (State or Foreign Country) Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Months Days Min. Hours 1**X** M 2□ F 229-20-9672 83 4-27-1925 Virginia Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov XXYes 2 □ No DC Director WASHINGTON 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 2104 T St SE 20020 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1943 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1946 1 ☐ Yes 2XNo Specify: Yes Give Specify:Black 2 3₺ Widowed 4 Divorced Year or Dates: 'natural", Completed event, I'm Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) DETAIL OPERATOR GOVERNMENT marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOSEPH GREEN MAMIE HARRTS မ traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Health a RUTH MINOR / SISTER 2104 T St SE Washington DC 20020 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any Injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8-27-2008 Triangle, VA Quantico National Cemetery 4 Donation 5 ☐ Other (Specify) Signature of Funeral Service Liver 22. Name and Address of Facility Washington DC Pope Funeral Home 2617 Penn Ave 20020 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner 10 CARDIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-trans Due to (or as a consequence of) Physician/Medical ast IF FEMALE nse ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy for Month Day 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown þ cate has been signed I page 2 should be dete 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No ector, 1 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 K ER/Outpatient 3 □ DOA this Medical Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, the Hospital or Attending Physician: filled in by the funeral after death. within 24 hours a To the Funeral I

the

Baltimore, Maryland 21215-0036

Registrar

29b. Signature and title of certifier

29a. Certifie

Name and

ompleted cause of death (Item 23a) (Type, Print)

and manner stated

29d. Date signed (Month, Day, Year)

1🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

PARKWAY GREET BEET MARYLAND 20770

**ORIGINAL** 

			For State Registrar		State	of Mary	land	/ Depa	rtmen tificate	t of He	ealth a Death	and M	ental Hy	giene Reg. No	200	8	270	72	
ř		1. Decedent's Name (First, Middle, Last)  Physician  Anna Gentile									2. Date Mon AUG					ear	3. Time of Dea		
	/Medic Examin		4a. Facility Name (If not ins			Town, or	Location o	of Death		40	4c. County of Death  Baltimore			<u></u>					
Ī	Funeral Director		5. Social Security Number 216-36-705	6. S	ex □M 2 <b>1</b> 27 F		yrs. las 79	st birthday) Yrs.	If Under Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Biri (Month, Da Oct • 1	th ly, Year	28	Birthpla Count	ace (State or Fo		
	laryland show ed at	o.		ent County Balti	more	100	c. City,	Town or Loc	ation							10	d. Inside City Li		
	with the N a or 28a-f be notifie	Direct	10e. Street and Number 2503 Bau			t Dri	VO		10f. Zip		1221			10g. Ci	tizen of Wha	t Count	ry?		
200	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:						Vas Deced Yes, spec	lent of His cify Cubar		gin? (Spe i, Puerto I	cify Yes or No Rican, etc.)	)-	14. Race -	White, e			
Z   Z   Z   Z   Z   Z   Z   Z   Z   Z	J within 72 hou jiene. r than "natura the Medical E	Completed	15. De (Specify only Elementary/Secondary ( 12th	-	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress						16b. Kind of Business/Industry Woolmouth								
/ומונת	uld be filed Mental Hyg irked other itic event, i	To Be C	17. Father's Name (First, Middle, Last) Guiseppi Mazolla						18. Mother's Name (First, Middle, M Elvira						flaiden Surname)				
, Mal	and 2 sho ealth and I n 27 is ma ier trauma		19a. Informant's Name/Re Sally Jam			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 2503 Bauernschmidt Drive Balto. I							MD	21221					
	Ly in Fig.		20a. Method of Disposition 1 ☑ Burial /2 □Crem 4 □Denation 5 □ O	Hol	Ty Redeemer 8/23/08 Balt								ation - City or Town, State						
Dal	permit. Departr Importa any inju		21. Signature of Puneral S	FIRE	HOR	<u> </u>			Conn	elly		nera	l Hom	e o	Ave. Balto. MD of Essex 21221 Approximate				
	Physician		23a. art1. Enter the dise shock, or heart failur Immediate Cause (Final disease or condition	ase, or com e. List only	plications to t one caus on a.	caused the each line.	death.	Do not ente	er the mod	e of dying	g, such as	cardiac c	or respiratory a	irrest,			Approximate Interval Betwee Onset and Dea		
	/Medical Examiner	_	resulting in death)  Sequentially list conditions	,	b	o (or as a co			<i>f</i> -/							_			
,0070	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions in any learning transport of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	c	o (or as a co		ence of):											
O. DOX 00	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregn in the past 12 month: 1 □ Yes ♣ No 9 □ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)					23d. Date of delivery Month Day Year				ır					
ecords, r.	quires that on signed by all be deta	by	Part II. Other significant conditions contributing to death but not resulting in the u							,g g					d tobacco use contribute to the cause of death?				
C	The law reate has bee page 2 shot	Completed									246					as an topsy findings average prior to completion of cause death?			
ומו	nysician: nis certific director,	To Be (	25. Was case referred to examiner?	I Hospital								26. Place of Death (Check only one)  utpatient 3 □ DOA Other: 4 □ Nursing Home 5 Residence 6 □ Other (Specify)							
	tending Pheath.	Certification:	27. Manner of Death  1 Natural 5  2 Accident	ear)							escribe how injury occurred								
	oital or At urs after d eral Direct	1 3	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factor building, etc. (Specify)							factory, office  28f. Location (Street and Number or Rural Route Nun City or Town, State)  courred at the time, date and place, and due to the cause(s) and manner as stated.							,		
	the Hosp thin 24 hor the Fune mpletely f	Medical		ledical Exar	miner: On the		aminatio		vestigation		pinion, dea			, date a		d due to	the cause(s)		
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	Sta Registr		AUG 2	2***2008	A COR	Registrar's	A.S. o	MARINE											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** HELEN VIRGINIA GREEN  $5:50 A^{M}$ 2008 AUG. 21, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** LONG VIEW NURSING HOME MANCHESTER CARROLL if Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days 1 □ M 2 🙀 F Yrs. 87 **Director** 4/07/1921 213-18-8572 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐ Yes 2 No Director MD CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be r 233 HOOK RD. 21157 USA death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status "natural", or item edical Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐ Yes 2 🗖 No Specify: <u>ک</u> Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) he 12 HOUSEWIFE HOME MAKER marked other 7 is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY ELIZABETH LINDSAY EARNEST RAY HAINES 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1308 WOODLAND DR., WESTMINSTER, MD RICHARD L. GREEN - SON Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any Injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/23/08 EVERGREEN MEM. GARDENS FINKSBURG, MD21. Sinnal red Funeral Solvice Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part. Finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate au e (Final disease or condition resulting in death) **Physician** /Medical or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Tes 2☐ No 3☐ Probably 4☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 : a□N( director. To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 100 40 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural Injury 1 Yes 2 No 2 ☐ Accident Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physician: after death I Director: / d in by the f within 24 hours a

To the Funeral I

completely filled

6

State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

address of person who co

eted cause of death (Item 23a) (Type.

MD

I 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c, License number

29d. Date/signed (Month, Day, Year)

Manchester, MD 2/102

/Medical Examiner **Funeral** Director with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Wedical Evantive roust be notified at death v 21215-0036 Health and Mental Hyginem 27 is marked other **Baltimore**, Maryland

> **Physician** /Medical Examiner

Department of Health a Important: If item 27 is any injury or other trains

Pages 1

AUGUST

GARMAN

CAROL

certificate be executed and tran attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 the 5 page 2 s has Physician: The certificate Hospital or Attending

10

Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 6 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) Certification: 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director; the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after hin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. ERNESTINE WRIGHT 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) AUG 2 2 2008 32. Registrar's Signatur State Registrar **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 12:00  $P^{M}$ Carol Ann Garman August 18, 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Stella Maris Timonium Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 🖾 F 10/14/1936 71 Maryland 213-34-5651 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 1 ☐ Yes 2 XNo Director MD Baltimore Rosedale 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 200R Potomac Ave. 21237 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 Never Married 2 Married ☐Yes 2XNo If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Information Operator Telephone 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Frederick Cooper Elsie Holm 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James A. Smith 3136 Walnut Shade Rd. Magnolia, DE. 19962 (son) Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 08/23/2008 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 22. Name and Address of Facility Duda-Ruck Funeral Home of 21. Sign Ture of Funeral Service Ligens e 7922 Wise Ave. Dundalk, MD. 21222 Dundalk, Inc. 23a. Part 1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LUNG CANCER Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Disease of Injury that initiated events resulting in death) Last

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup>2008 **Physician** Month August 18. 4:30 P M Marie Alma Gangler /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Baltimore Stella Maris Timonium 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, September 9. Birthplace (State or Foreign (In yrs. last birthday) 87 Yrs. **Funeral** Days Hours Months 1 □ M 2 🛛 F 213-03-9508 Maryland 1920 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Modical Examinar must be notified at Baltimore Maryland Parkville Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA 3200 Texas Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2√X No Specify: White Specify: 9 3 XWidowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important; If item 27 is marked other than "ne any Injury or other traumatic event, Ite Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Pharmacy Technician Medical Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph E. Drury Nora M. Moran ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John M. Gangler Jr. / Son 3200 Texas Avenue Baltimore Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer 8/20/08 Baltimore Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Leonard J. Ruck, Inc. Musteria 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Destronglive hong Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Ye ar 5 ☐ Other (specify) Division of Vital Records, P.O. the 9 Ulnknown 9 Unknown Ś signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 2/2010 selection After this certificate 1 ☐ Yes 2 □No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 dursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I Lestifying hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical 29a. Certifier (Check only one) and manner stated. within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 19.00

State Registrar

AUGUST

MARIE

TIMONIUM, MD 21093

2300 DULANEY VALLEY ROAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signatu

EDDIE NAKHUDA, M.D.

31. Date filed (Month, Day,

AUG 22

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2:18 a<sup>M</sup> SALVATORE AUGUST 19 2008 S. GANGI 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE HOSPITAL HARFORD BEL AIR er 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday Days Hours Min 1 X M 2 □ F 79 220 24 9380 1/07/1929 MARYLAND Usuai Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits STREET 1 □Yes 2 No HARFORD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21154 3208 CONOWINGO ROAD 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: KOREA 1 Never Married 2 Married WHITE 1 □Yes 2X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ROAD DRIVER TRUCKING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SALVATIORE GANGI ROSE RAPPA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EVELYN A. GANGI / WIFE 3208 CONOWINGO ROAD STREET, MD 21154 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State METRO CREMATORY 8/21/08 4 □ Donation 5 □ Other (Specify) BALTIMORE, MD 21. Signature of Funeral 6 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211CHESACO AVE BALTIMORE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final taute disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a, State

MD

Director

Funeral

2

Completed

Be

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**Funeral** 

Director

show

7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, ™ ™odical Examiner must be notified at

death with the Maryland

8/19/08 02.(87) Baltimore, Maryland 21215-0036

Examiner Physician/Medical

signed by the attending physician and I be detached for use as the burial-tran þ Completed Be Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Linknown

27. Manner of Death 1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy perform 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 28b. Time of Injury 5 Pending investigation 1 □ Yes 2 🗆 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chaapeake Dr. Bel M.D. 500 Upper arr 31. Date filed (Month, Day,

State Registrar

cal

Hospital or A

To the Hospital of within 24 hours at To the Funeral D

The law requires that the death certificate be executed burial-transit and Division or Vital Records, P.O. Box 68760, as nse for detached Hospital or Attending Physician:

**Funeral** 

Director

"natural", or Items 23a or 28a-f show adical Examiner must be notified at

filed within 72 hours after death with the Maryland Hygiene.

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If item 27 is marked other any Injury or other traumatic event, #

**Physician** /Medical-

Examiner

Baltimore, Maryland 21215-0036

filled in by the funeral director, Certification: To 24 hours after death e Funeral Director; Medical

1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

Registrar

State

completely

within 2

DARSHAM 31. Date filed (Month, Day, Year)

AUG 22 2008

1600 W. MOUNT Royal Ave, Balto MD S. SALUIA MD 82. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

08-06235 William Paul Hampton

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 27078

rillani i adi i iai	· ·	1-For State Of Maryland / Department of Health and Me Registrar Certificate of Death	entarriygiene	Reg. No.	300 2101					
Physicia	an/	Decedent's Name (First, Middle,Last)	2. Date of Month	Death Day Year	3. Time of Death					
ledical Exami	ner	William Paul Hampton  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location		t 14, 2008	1745 hrs					
		108 Gwen Drive Forest Hill		Harford						
Funeral Director		470–98–9736 1X M 2 F 41 Yrs. Months Days Ho	ours Min.		Birthplace (State or Foreign Country) Labama					
any .	ŀ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits					
<b>*</b>	٥	Maryland Harford Forest Hill			1 Yes 2 X No					
th the Maryland 23a or 28a-f sho	e l	10e. Street and Number 10f. Zip Code		10g. Citizen of What (	Country?					
ith the notific		108 Gwen Drive, Unit M 21050  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic	Origin? ( Specify Yes o	U.S.A.	merican Indian, Black,					
leath w	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexic								
after c	by F	3 Wildowed 4 X Divorced of Pear 87–89 1 Yes 2X No spec	·		White					
2 hours "natu		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)		16b. Kind of Busine	ess/Industry					
0036 within 72 hours after death with the Maryland jene. ner than "natural", or items 23a or 28a-f she Medical Examiner, must be notified at once	Completed	12 Manager		Retail						
21215-0036 uld be filed within 72 hours after Mental Hygiene. nnarked other than "natural", c event, the Medical Examiner			other's Name (First, Mid ndrea Lori	Idle, Maiden Surname)						
212 uld be Menta marke c even	ш	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and I			State, Zip Code)					
MD ¢ 2 sho lth and n 27 is	7	Wendy Wingerd (Friend) 108 Gwen Drive,								
		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery crematory or other place)		20c. Location - Cit						
C 0. 0 F L		Bayview Crematory, In								
Baltir permit.: I Departm Importa injury o		21. Sign of the of Frings Service Licensee  22. Name and Address of Far Bruzdz  1407 Old Fast	zinski Fune Fern Avenue	eral Home, P	A.					
Physician		23e. Part 1 offer the disease, or complications that caused the death. Do not enter the mode of dying, such a failure. List only one cause on each line.	22. Name and Address of Facility Bruzdzinski Funeral Home, I 1407 old Eastern Avenue, Essex, Ma 3c. Pert 1 sher the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear							
/ */Medical xaminer		Imprediate Cause (Final disease a. Coronary Artery Thrombosis			Between Onset and Death					
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions  b.								
	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of); cause. Enter Underlying Cause								
_ =	Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):								
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760, ficate be executed physician and the burial - transit	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of del	livery					
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Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) g Unknown		-						
the bar in the second	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	_	Did tobacco use contribut						
S, P.C puires that en signed	ed by				Probably 4 V Unknown					
tal Records, tian: The law requir certificate has been s ector, page 2 should l	Completed				re autopsy findings available r to completion of cause of th?					
Rec: The liftcate liftcate l		25. Was case referred to medical 26.Place of De			Yes 2 No					
Vital F hysician: this certifi al director,	o Be	examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other		5 Residence 6 ✔ (	Other: Scene					
n of V ling Phy After tl funeral	-1	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at W	Work? 28d. Desc	cribe how injury occurred						
Sion Attendideath. Sctor:	catio	2 Accident Investigation	2 No		B -1 B - 1 N -1 - 0"					
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should it	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building (Specify)		own, State)	or Rural Route Number, City					
Hospi 24 hou Funer tely fil		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and								
To the within To the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.								
	Σ	29b. Signature and title of certifier  29c. License num  O.C.M.E.		29d. Date signed August 15, 20	(Month, Day, Year)					
		30. Name and address of person who completed cause of death (Item 23a)	·	1,109051 10, 21						
XV		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, M	MD 21201							
St Regis	ate	11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1								
Regis	ıcı									

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month BLANCHE UROVE P M August 18. 2008 4:56 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 24 Hrs. 7. Age (In vrs. last birthdav) Months Days Hours Min 220-20-2067 1 ☐ M 2 🔀 F MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BALTIMOLE ALTIMORE Nd. 10e. Street and Number 10g. Citizen of What Country? 21208 U.S.A. MALKSTONE 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: BLACK 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WORKER 18. Mother's Name (First, Middle, Maiden Surname. 17. Father's Name (First, Middle, Last) SMITH BLANCHE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MARGROVE -DANGH BACTO. Md. 21216 20b. Place of Disposition (Name of \_cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 Removal from State OWENDS MELLS, Med. 21. Signature of Funeral Service License 2700 EdMONDSON AVE. - BALTO. 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SERSU SYNPROME disease or condition resulting in death) Due to (or as a consequence of): HERNIA HCARCEMIED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Unpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show

Funeral Director

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Be Completed

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7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examiner must be notified at

other

permit. Pages 1 and Department of Heal Important: If item 2 any injury or other once.

filed within 72 hours after death with the Maryland

and 2 should be

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burial-tran physician the attending p for use as t ed by the vis certificate has been signed by director, page 2 should be detach After this funeral

Hospital or Attending PhysIclan; The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records.

Examiner Physician/Medical \$ Completed Be Certification; To filled in by the

9 Unknown

1 Yes 2 No

5 ☐ Pending investigation 1 Natural

2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28a. Date of Injury (Month, Day, Year) 28b. Time of

and manner stated.

person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

State Registrar

Medical

29a. Certifier

(Check only one)

30. Name and address of

31. Date filed (Month, Day, Year)

NIG 2 2 2008 2 2

653 32. Registrar's Signature

24 hours after death Funeral Director:

within 2 To the I

completely

Randolp

P.O. Box 68760, of Vital Records,

For Amend Item 25 per me, g882,08/20/08dhb Certificate of Dooth 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 21 230 PM Randolph A. Harding 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale FRANKLIN SQUARE HOSPITAL CENTER Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 5-6-1921 9. Birthplace (State or Foreign 6 Sex **Funeral** Months Days Hours Min Year) Country) 1 X M 2 □ F Director 215-14-6789 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Wodical Examinating the notified at 1 ☐ Yes 2 ☐ No Director Balto. Nottingham Md. 10g. Citizen of What Country's 10e. Street and Number 10f. Zip Code 7 Wood Oak Ct. 21236 USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 X Yes 2 □ No Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 🗓 No White Specify: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Georgia Boring Randolph A. Harding ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Sandy Harding 7 Wood Oak Ct. Nottingham., Md. 21236 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood 7-25,2008 Parkville 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Gastrointestinal Bleeding Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HyperTension Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examine signed by the attending physician and de detached for use as the burial-transi MULTIPLE Abdominal that initiated events Due to (or as a consequence of): resulting in death) Last CERTIFICATION Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s certificate 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 ⚠ Yes 2 ☑ 1 ☑ 100 Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After I or Attending I after death. Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident reral Director; refilled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 237867 RESODD Mane 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mangal 9000 FRANKLIN Square DR Baltimore DR walid 1 2008 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day AUGUST 19, HERBERT JENNINGS 2008 7:00 A IRELAND /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 231 Garnett Road Harford Joppa 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 → M 2 □ F Director Mar. 13, 1930 North Carolina 240-38-1503 78 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits notified at **Funeral Director** 1 ☐ Yes 2 ☐XNo 28a-f Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Mcdical Examiner must be a 21085 USA 231 Garnett Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Ma Yes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Education Music Instructor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert Jennings Ireland Blanche Bell Ball ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary D. Ireland / Wife 20a. Method of Disposition 231 Garnett Road, Joppa, Maryland 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 【ICremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 8-22-08 Towson, Maryland of Funeral Service Licenses McComas Funeral Home, P.A. tefle 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ventricular /Medical Due to (or as a consequence of): Examiner 23 years Due to (or as a consequence of): Se juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year ed by the a detached f 5 Other (specify) P.O. 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has funeral director, page 2 perform 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \sum Nursing Home 2 ER/Outpatient 3 DOA P 1 Inpatient this 5 Sesidence 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: or Attending 5 ☐ Pending investigation 1 Natural n 24 hours after under the Funeral Director: Af 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Fune completely fi (Check only one) 29b. Signature and aitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 751 MD 2008 1

State Registrar

ania 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

e and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

AMEND TIEM#10e, periff, G882,8/22/08, WS

State of Maryland / Department of Health and Mental Hygiene 2 27082 1 - For State Registrar Certificate of Death Reg. No.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 Phys /Me Exar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending physician and

Division of Vital Records, P.O. Box 68760,

Physicia /Medic	O. LEE OUTES												3. Time of 9:30	Death P M	
Examin		4a. Facility Name (If n 205			#1009		4b. City, Town,		of Death			inty of Death .ltimor	е		
Funeral Director		5. Social Security Nun 215-01-355 Usual Residence of D	58	.Sex 1XIM 2□F	7. Age (In yrs. 94	last birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Bir (Month, D. Dec. I	4, 191		olace (State o	or Foreign	
Ba-f show	Director	10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits 1 □ Yes 2 ☒ No					
23a or 2	ral Dire	10e. Street and Numb	Joppa Kabara	<u>Rd</u> . #100	)9		10f. Zip Code 2128	6			10g. Citizen	g. Citizen of What Country?			
o'.'a	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:				r in U.S.  13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica  1 □ Yes 2 No Specify:					cify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify hi te				
giene. er than "natu , the Weden	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-40r 5+) 5+			5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	ing	Systems Analyst						
Mental Hy narked other natic event	To Be (	17. Father's Name (First, Middle, Last) William Roswell Jones						Mar	у В	ecker					
Health and em 27 is n ther traum		Mr. Brian 20a. Method of Dispos	Jones/		20h F	205 E	ng Address (Stree	Rd. #	100		n, Md.	21286			
urtment of urtant: If its njury or o		1 ☐ Burial 2 🗖 ( 4 ☐ Donation 5	Cremation 3 ☐Other (Spec	cify)	State	1top S	sition (Name of matory or other place)	0.	8 <b>-</b> 20	-08	20c. Location - City or Town, State Towson, Md.				
Impo any I		21. Signature of Fune		Inc 21204 Approximate											
ysician Medical		23a. Part 1. Enter the diseast or complications the clused the death. Do not enter the mode of dying, such as ordiac or resolutory arrot.  Approximate Interval Between Onsel and Death Onsel													
aminer tausit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):													
attending physician and for use as the burial-transit	ωļ	resulting in death) Las	st	Due to (	or as a consequ	uence of):									
y the attending ched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pr in the past 12 mo 1 ☐ Yes 2 ☐ N 9 ☐ Unknown	onths?	23c. If yes, out 1 ☐ Live t 4 ☐ Pregr 9 ☐ Unkn	Fetonic pregnancy					Date of delive	-	/ear			
en signed b	ਨੂ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									obacco use c		ne cause of d		
To the Funeral area occur.  To the Funeral area occur.  Completely filled in by the funeral director, page 2 should be detached	Completed	185								24a. Was autoj perfo	psy ormed?	hb. Were auto prior to co death? 1 🗌 Yes	mpletion of ca	available ause of	
rector	20	25. Was case referred examiner?		Hospital:			Ot	oor.		(Check only o					
r: After this	ation: To	2 Accident	5 ☐ Pending investigati	28a. Date (Mont	npatient 2  of Injury th, Day, Year)	28b. Time o Injury	f 28c. Inju	ry at		me 5 Aesi 28d. Describe			ý)		
ral Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	28e. Place	of Injury - At hong, etc. <i>(Specif</i> )		eet, factory, office			28f. Location ( City or To		mber or Rura	il Route Num	ber,	
the Funer	Medical	(Check only 2) one)	☑ Medical Exa	aminer: On the ba	best of my kno- asis of examina her stated.	wledge, deat tion and/or in	h occurred at the avestigation, in my	opinion, de	nd place, ath occur	and due to the red at the time,	date and place	ce, and due to	the cause(s	)	
(3)		29b. Signature and title	10	80	<i>Y</i>		29c. Licen	301	49		29a, Dafe/sig	gned (Mohth,	Day Year)	_/_	
20		30. Name and address 31. Date filed (Month)	Iva	750	e of death (Item	5/012	30 Print)	2	10	050	N K	W)	nn	K	
State Registra	r	AUG 2		307	s d	Span	W							_	

DHMH 17 Rev 1/2001

			State of Manyland / Department of Health and M  1 - For State Registrar Regi	ental Hygiene Reg. No. 2008 27083
	Physicia /Medic	an al	1. Decedent's Name (First, Middle, Last)  Educated H. Johnson	2. Date of Death  Day  Year  4c. County of Death
	Examin Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yeak) 9. Birthplace (State or Foreign Country)  5 - 1 - 15 DATE MORE MD
	a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  PA YORK 10c. City, Town or Location	10d. Inside City Limits 1 □ Yes 2 No
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hyglene. Itam 27 Is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	Funeral Director	10e. Street and Number  10f. Zip Code  17353  11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent Of Hispanic Origin? (Specific Property of the Control Proper	10g. Citizen of What Country?  USA  1cify Yes or No-  14. Race - American Indian,
9800	nours after d ural', or Itan Il Examiner	by	3 Widowed 4 Divorced Year or Dates:	Black, White, etc.  Specify: White  16b. Kind of Business/Industry
21215-0036	filed within 72 h Hygiene. Ither than "nati	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)	Clan Automotives
Maryland	should be file ind Mental Hy s markad oth umatic evant	To Be (	17. Father's Name (First, Middle, Last)	(First, Middle, Maiden Sumane)  Mary Jane Hnipps  Al Route N Imber, City or Town, State, Zip Code)
	Pages 1 and 2 sho nent of Health and i nut: If itam 27 Is mu iry or other traums		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of competery, crematory or other place)	Date 20c. Local nn - City or Tilwn, State
Baltimore,	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility New  Evans Funeral Ch	uport Dr. FurestHill, MD 2N50, apel + CKmation Services - Believ
	Pnysician /Medical	(i)	23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a	or respiratory arrest, Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	OTED BY MEDICAL EXAMINER
,0928	icate be executed physician and s the burial-transit	icai	d.	
.O. Box 6	ath certifi titending or use as	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	23d. Date of delivery  Month Day Year
<u>α</u>	w requires that the de been signed by the a should be detached f	by	Takin, Guld Significant South States (1997)	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
al Records,	ding Physician: The law re h. After this certificate has be funeral director, page 2 shc	Completed		24a. Was an autopsy performed?  154 Yes 2 \sum No
Vital	Physician: r this certificatal director,	o Be	examiner?	h <i>(Check only one)</i> ome 5 ☐ Residence 6 ☐ Other <i>(Specify)</i>
of	ding Phys h. After this funeral di	n: To		28d. Describe how injury occurred of the and
Division	To the Hospital or Attending Within 24 hours after death. To the Funaral Diractor: Afte completely filled in by the fune	Certification:	1 Natural 5 Pending investigation 2 RAccident 3 Suicide 4 Homicide Homicide 1 Pending (Notice building, etc. (Specify) 1 Pending 1 Pending (Notice building, etc. (Specify) 1 Pending 1 Pe	Pick up truck impact 281. Location (Street and Number or Rural Route Number, City or Town, State) Route 136 at Doole rd Belain,
	To the Hospital or Attent within 24 hours after death To the Funaral Diractor: completely filled in by the	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) and manner stated and place, and manner stated	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)
	Tou	W	29b. Signature and title of certifier 29c. License number 4005 442	29d. Date signed (Month, Day, Year)  7 - 2 4 - 0 8
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Cyrus Asadi, 20 E. Timonium rd. #209 Timo.	nium, MD 21093
	Sta Regist	ate rar	1 0 2009 Real & Cotal	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7 0 8 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month August 18, 2008 2:00  $A^M$ Valerie Jane Koel 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Towson Gilchrist Nursing Center If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Months 1 □ M 2 🖾 F Maryland 09/10/1949 213-52-9787 58 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 XNo Dundalk Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 22 Broadship Rd. 21222 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2★ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: White 3 ☐ Widowed 4 🔀 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Social Services Elementary/Secondary (0-12) College (1-4or 5+) Baltimore County 12 Finance Department 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth E. Tumbleson William E. Waldman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Broadship Rd. Dundalk, MD. 21222 (daughter) Valerie G. Koel 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Middle River, MD. ☐Donation 5 ☐Other (Specify) Holly Hill Mem. Gdns 08/22/2008 21. Sign ture of Funeral Service I 22. Name and Address of FacilityDuda-Ruck Funeral Home of Dundalk Dundalk, MD. 21222 7922 Wise Ave. Inc. Approximate Interval Between Onset and Death 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 🗆 Ectopic pregnancy Day Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

Director

Funeral

þ

Completed

Be

MD

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examinar must be nofified at

12 should be filed w. h and Mental Hygier 7 is marked other th

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau

Baltimore, Maryland 21215-0036

and burial-trar attending physician the as use ō signed by the a has certificate e Hospital or Attending Physician: 124 hours after death.
e Funeral Director: After this certificalety filled in by the funeral director, p.

Box 68760.

P.O. I

Division of Vital Records,

certificate be

Examiner Physician/Medical þ Completed Be Certification: To

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

Hospital:

5 Pending investigation 6 □Could not be determined

28a. Date of Injury (Month, Day, Year) 28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specification)

1 ☐ Yes

2 🗆 No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

autopsy performe

1 ☐Yes 2 ☐No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2 19 No

1 ☐ Yes

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a, Certifier

Medical

4 Homicide

and manner stated.

29c. License number

Churles St.

29d. Date signed (Month, Day, Year) 18,2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bin( 6701 A.K.le

31. Date filed (Month, Day, Year)

32 Registrar's Signature

ORIGINAL

State Registrar

completely

within 2

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 27085 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month D. SIPM 2008 PATTY LOUISE KARL と 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Huga tal Daltimore 0 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Hours Months Days 1 □ M 2 🔀 F 24, 1954 Maryland <u> 218–64–4665</u> Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ☑ No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2005 Nuttal Ave. 21040 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tyes 25 No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 ☐ No Specify: Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) <u>Clarence F. Martin</u> Patsy Sue Fletcher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charles J. Karl / Husband 2005 Nuttal Ave., Edgewood, MD 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillton Service Com 8-21-08

**Physician** /Medical Examiner

permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 Is
any Injury or other trau

**Physician** 

Examiner

**Funeral** 

Director

of 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.

27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exercites must be notified at

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Baltimore, Maryland 21215-0036

/Medical

Director

Funera

Completed

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burial-trar attending physician for use as the buria ned by the detached signed by the detach page 2 s



	5	( M)
λ	7	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
		THOMAS GENERALLY MD, SING
	State	31. Date file (Month, Pay Year 1) 18 / 182 Registrar's Annature
	Registrar	

	23a. Part1. Enur the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	lication, that caused the death. Do not enter the rine cause on each line.	mode of dying, such as cardiad	or respiratory arrest,	Maryland 21009  Approximate Interval Between Onset and Death						
al Examiner	Due to (or is a consequence of):  Sequentially list conditions, lieuwed to form as a consequence of):  Due to (or is a consequence of):  Due to (or is a consequence of):  Due to (or as a consequence of):										
ysician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1										
ed by Pl	Part II. Other significant conditions co	ntributing to death but not resulting in the underlyin	ng cause given in Part I.	23e. Did tobacco u 1 □ Yes 2	se contribute to the cause of death?  No 3 Probably 4 Unknown						
Completed by Pl	Part II. Other significant conditions co Mix bid obesing Mutastatic Hypertesis	ntributing to death but not resulting in the underlying the care care.	ng cause given in Part I.		No 3 Probably 4 Unknown						
3e Completed by Pl	mirbid obsin	ty		1 ☐ Yes 2 0	24b. Were autopsy findings available prior to completion of cause of death?						
Be	mitostatic  Hy pertension  25. Was case referred to medical examiner?	ty	26. Place of Dea	1   Yes 2    24a. Was an autopsy performed? 1   Yes 2   No ath (Check only one)	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No						
Be	m or bid obsine to the state of the pertens of the examiner?	Cancer	26. Place of Dea	1 ☐ Yes 2 €  24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No						
Be	Michiel obesing the state of th	Hospital: 1 Inpatient 2 ER/Outpatient 3 ER/Outpatient 3 Inpatient Day, Year) 28b. Time of Injury	26. Place of Dec  J DOA Other: 4 \( \text{ Nursing F} \)  28c. Injury at \( \text{ Work?} \)  1 \( \text{ Yes} \) 2 \( \text{ No} \)	24a. Was an autopsy performed? 1 \[ Yes 2 \] 24a. Was an autopsy performed? 1 \[ Yes 2 \] 28 No ath (Check only one) 10 me 5 \[ Residence 6 \] 28d. Describe how injurity	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2  No  G Other (Specify)  y occurred						
dical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural investigation 3 Suicide 4 Homicide  29a. Certifier  1 Certifying Physical Conditions and the determined	Hospital: 1 Inpatient 2 ER/Outpatient 3 ER/Outpatient 3 Inpatient 2 Ba. Date of Injury (Month, Day, Year) 28b. Time of Injury M	26. Place of Dea  DOA Other: 4 \( \triangle \) Nursing F  28c. Injury at Work? 1 \( \triangle \) Yes 2 \( \triangle \) No  Story, office	24a. Was an autopsy performed? 1 Ves 2 No ath (Check only one) tome 5 Residence (28d. Describe how injur. 28f. Location (Street an City or Town, State)	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  y occurred  d Number or Rural Route Number,						
Medical Certification: To Be Completed by Pl	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	Hospital: 1 Inpatient 2 ER/Outpatient 3 ER/Out	26. Place of Dea  DOA Other: 4 \( \triangle \) Nursing F  28c. Injury at Work? 1 \( \triangle \) Yes 2 \( \triangle \) No  Story, office	24a. Was an autopsy performed?  1   Yes   2   Mo ath (Check only one)  dome   5   Residence   6    28d. Describe how injured at the time, date and autopsy performed?  28f. Location (Street and City or Town, State)	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  y occurred  d Number or Rural Route Number,						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3. Time of Death Jenny Month Kehoe Day /Medical August 20, 2008 10:30 A Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1566 Glen Keith Blvd. Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb 6, 1923 9. Birthplace (State or Foreign 1 □ M 2 🙀 F Director 219-18-3526 85 Maryland Usual Residence of Decedent 10a, State 10b. County 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Towson 1 ☐ Yes 2 ☐ XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1566 Glen Keith Blvd Funeral 21286 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 ☐XNo Specify.

filed within 72 hours after death with the Maryland 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Be Completed by 3 ☐ Widowed 4 ☐ Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired)
 permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nr any Infury or other traumatic event, It is Medit once. 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marion ပ Bruno Annie Garbo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Winfield-daughter 14210 Sawmill Ct., Phoenix, MD 21131 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Entombment Dulaney Valley Mem. 8/23/08 Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Τοωson, Maryland\_ Ruck Towson Funeral Homé, 23a. Part1. Enter the disease, or complications that paused the death shock, or heart failure. List only one course on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (okas a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant at time of death 1 ☐ Yes 5 ☐ Other (specify) Day signed by the Month Year 9 Unknown 9 Unknow Part II. Other significant conditions contribut death but not resulting in the underlying cause given in Part I. <u>á</u> 23e. Did tobacco use contribute to the cause of death? Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown has 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy perform 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Certification: To 1 Yes 2 ¥ Hospital: Other: 4 \sum Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation after death. 2 Accident 1 ☐ Yes 2 🗆 No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Medical Examiner: On the basisyof examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check o one.

P.O. Box 68760, of Vital Records, completely filled in by the funeral director, Division ithin 24 hours a To the within 7

> W State Registrar

29b. Signature and title of certific

39. Name and address of person who

31. Date filed (Month, Day, Year)
AUG 2 2 2008

mpleted cause of death (Item 20a) (Type, Print) 1445/10 32. Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM 196, 206 C. per FH #246, per PHYS C882, 8/22/08
State of Maryland, Department of Health, and Mental Hygiene 200 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** KLEPACH ALECSANDR /Medical 4a. Facility Name (If not institution, give street and num) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospitalo Ballonge Raltinge If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 01/12/1957 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F RUSSIA Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is anarked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, trained to be a single or other traumatic event, trained at 1 ☐Yes 2 ☐ No Director BALTIMORE MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21215 6940 BROOKMILL ROAD, APT. T-2 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Part Known of Hecsandy Baltimore, Maryland 21215-0036 1 ☐ Never Married 2 💢 Married WHITE 1 ☐ Yes 2 📉 No Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) COMPUTERS COMPUTER TECHNICIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be POGORELOV KLEPACH GALINA EFIM 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6940 MILLBROOK ROAD, APT. T-2, BALTIMORE, 19a. Informant's Name/Relationship (Type. Print) -ROAD, APT. T-2, BALTIMORE, MD 21215 IRINA LIHTIN/ WIFE 20b. Beersheya (Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 08/21/2008 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 21. Signature of Funeral Service Licerses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 1 Scending **Physician** 2 day asitic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1⊞Yes 2□No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 1 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Aliquest 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

08-06292 David Lewis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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d Lewis	1- F	or State	Sta	ate of N	Maryland	/ Depar	tment of ificate of	Health an Death	nd Menta	al Hygiene	Reg. N	. 2(	008 2	708
Physician/		istrar Decedent's Name	e (First, Middle	e,Last)						2. Date of Month	of Death Day St 17, 20	Year	<ol><li>Time of Death</li><li>0207 hrs</li></ol>	
ارتعا Examine	r	David F	ngene	Lewis	5			b. City, Town,	- Langtion of		st 17, 20	4c. County of Death		
	4a	Facility Name (in	f not institution	n, give stre	et and numbe	ır)	\'	Baltimore	or Location of	Death		N/A		
		Johns Hopk		6. Sex		Age (In yrs. las	st birthday)	If Under 1 Y	ear If Under	24Hrs. 8. Date	e of Birth (M	M/DD/YYYY) 9. Bir	thplace (State or	
Funeral Director	1	Social Security N					Yrs	1 1	ays Hours	Min. Oct	t. 12		untry) Marylar	ıd
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h the last or southfile			25 East Fairmount Avenue 21224									14. Race - Amer White, etc.	rican Indian, Black,	
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212 ould be Ment Ment is mark	$\sim$ $-$	19a. Informant's N Is. Este	Jama/Dalation	ship (Type	e, Print) is (Dau	ohter)	19b. Maili 175	ng Address (S	treet and Num	ad Cop	oute Number	er, City or Town, Sta o, Md. 21 hore, Mar	918 2122	24
more, MD 21215-0036  Pages I and 2 should be filled within 72 hours after death with the Maryland tent of Health and Montal Hygieral and marked other than "natural", or items 23a or 28a-f sho in the Traumatte event, the Medical Examiner must be notified at once or other traumatte.	- 11	vina C.	Lowis	(Si	ster-ir		Place of Disp	osition (Name of	f cemetery,	Date	1	20c. Location - City	or Town, State	
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Baltimore, bermit. Pages I ar Department of Hee Important: If itel			5 Other	Specify:		H:	illtop   22	Service Name and Ad	ress of Facilit	y 23/2	me of	Dundalk,	Inc.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of	Funeral Servic	ELICEISE	Lan	4	!	Duda-Ru 7922 Wi	se Aver	nue Du	ndalk	Marylan	d 21222 Approximate Inte	torval
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—transi	Med	IF FEMALE:			P-1	outcome of pre	egnancy		3 Ector	pic pregnancy		23d. Date of deli Month	ivery Day Yea	ar
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Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certiff completely filled in by the funeral director,	Certification:	3 Suicide		determine	d (Specify	)	HOME							шо
Hosp 24 hor Fune stely fi	la C			ng Physic	ian: To the be	est of my know	vledge, death on and/or inve	occurred at the estigation, in my	time, date and opinion, death	d place, and due h occurred at th	e to the cau e time, date	use(s) and manner a e and place, and due	e to the cause(s)	
To the I within 2 To the I	Medical	one) 2	- Line	1	and manner	stated.			. License num			29d. Date signed	(Month, Day, Year)	
	Σ	29b. Signature	and title of	er tiple /	/ (				O.C.M.E.			August 17, 2	2008	
		30. Name and	addraga de -	ersonwho	completed ca	use of death (	(Item 23a)							
OCME			Ripple M		puty Chief	Medical E	xaminer	111 Penn	Street, Bal	Itimore, MD	21201			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Margaret Ellen Moser /Medical (If not institution, give street and number, Examiner Home tizens Nursina Havre de Grace Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1□M 2√2 F Director Virginia Dec. 24, 1928 223-30-8420 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2☐ No Director Maryland Harford Perryman 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1515 Maple Avenue 21130 <u>United States</u> Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ৄ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Plott Roberta Short 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Quoos (Daughter) 57 Leona Drive Conowingo, Maryland 21918 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 8/23/2008 Covington, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part1. He iter the dis. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Isch **Physician** eun /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to or as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE. 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed After this certificate 1∐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 27. Manner of Death 1 Natural 28a. Date of Injury 28h Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation within 24 hours and To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D32609 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) evolution St. Howre De Grayers 21078 Milhanino 1106 A 31. Date filed (Month, Day, Year) AUG 2 2 2 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Amelia Gladys Moltz 2008 6:15 a. 17 Aug. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Northwest Hospital Center Randallstown Baltimore Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) 1 □ M 2√2 F Months Days Hours Min. **Director** 212-10-2725 2, 1918 Maryland Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Funeral Director 1 ☑ Yes 2 ☐ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3613 Hudson Street United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. traumatic event, the Madical Examiner 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 Yes 2 No Specify þ Specify: 3€XWidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Kroening ۵ Emma Hayes Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys Caughy (Daughter) 6701 Duluth Avenue Dundalk, Maryland 21222 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot once. 1 🙀 Burial 2 □ Cremation 3 □ Removal from State 8/20/2008 4 Donation 5 Dother (Specify) Oak Lawn Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 art1. Enter the disease omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** cardiothranbotic event disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be within 24 bours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burn Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 mont Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ Mo 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Johknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 100 2 No 1 ☐ Yes 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann f Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Unatural 5 Pending investigation

P.O.

Baltimore, Maryland 21215-0036

Division of Vital Records.

State Registrar

Medical

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

D0057465

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

8/17/08

> Lyapalle NIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

6 ☐ Could not be

determined

25 mainst, Suite 200, Reisterspour , MD. 21136

N.S. KAJUPAKHMD 31. Date filed (Month, Day, Year, Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Amend #2, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Aug. 2008 Time of Death **Physician** AUGUST 19, 2008 EVA HATTIE OSBORNE 23:57 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE HARFORD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 🔏 F Director 234-32-7329 87 Yrs Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1X Yes 2 No Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 South Market St. 21078 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XNo δ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within 7 al Hygiene. Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be file frient of Health and Mental Hi tant: If tem 27 is marked off jury or other treumatic even 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ George (nmn) Welch Bertha Mae Roten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Nancy F. Pace / Sister 1413 Emily Court West, Abingdon, Maryland 21009 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn 8-25-08 Bel Air, Maryland McComas Funeral Home, P.A. mas 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Se. PSIS **Physician** 48 hours /Medical Due to (or as a consequence of) Examiner ract Infection S—uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque ce of Due to (or as a consequence of) Certification: To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No of Vital 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Natural

2 □ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 Pending investigation 1 Tes 2 No Director: / 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 035012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Upper Chesapenke Bel Air, Md. 21014 J. Kevin LywiH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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08-06354	ļ
Richard F	9226

State of Maryland / Department of Health and Mental Hygiene 2008 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day August 20, 2008 0009 hrs Medical Examiner Richard Peace 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** Johns Hopkins Hospital If Under 1 Year | If Under 24Hrs. . Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Director Country) 2 Yrs 213-31-3453 1\_**X**M MD Usual Residence of Decedent JIV. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No 28a-f show notified at once, MD N/A Baltimore with the Maryland 10g. Citizen of What Country' 10e Street and Number 10f. Zip Code Streeper Street 21205 800 N. USA Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 XNever Married 2 Married 01. Yes Black Widowed Divorced If Yes, Give Year Yes 2X No specify: Specify: hours after 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filted within 72 I nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "
or other traumatic event, the Medical I Unemployed MD 21215-0036 Unemployed 9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Troy D. Peace, Denise Taylor 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Troy Peace, Sr-Streeper Street MD 21205 Balto, Baltimore, N permit. Pages I and Department of Healtl Important; If item injury or other trau 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 XBurial 2 Cremation 3 Mt Zion Cemetery 8-29-08 Lansdown, MD Other Specify Donation 5 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H East Dame C 0 1101 Ε. MD 21202 North Avenue Balto Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical a. Multiple Blunt Force Injuries Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed and Physician/Medical **#8 per FH G882 8** 28d,perME,G8839, UNPENDED X AMENDED attending physician Box 68760, IF FEMALE: 23d. Date of deliver 23c. If yes, outcome of pregnancy as the t 23b. Was decedent pregnant in the Live birth Year Fetal death 3 Ectopic pregnancy Month Day 2 past 12 months? use Pregnant at time of death Other (Specify) ed by the att Yes 2 No 9 Unknown Unknown signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ₽ Yes 2 ✔ No 3 Probably 4 Unknown Completed has been s 24a. Was ar 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? page 1 🗸 Yes 2 2 No certificate 1 V Yes 26 Place of Death (Check only one) 25. Was case referred to medica Be Other<sub>4</sub> examiner? Hospital: Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other After this ۵ 1 Yes 2 No 28a. Date of Injury 28d. Describe how injury occurred Operator in 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Aug 19, 2008 assenger dirtbike auto collision 2337 hrs Natural Yes 2 V No Pending death. To the Funeral Director: the lirt bike/ auto collision 2 Accident Investigation þ 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide filled in or Town State) determined (Specify) Local Street E. Lafayette Avenue & N. Wolfe Street, Baltimore, MD Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E August 20, 2008 21 1 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Russell Alexander MD. Assistant Medical Examiner 31. Date filed (Month Pay, Year) AUG 2 2 32. Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Powell 2250 Georgianna Agnes 08 18 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE WASHINGTON MEDICAL COUTER GLEN BURNIE ANNE ARUNOEZ If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. April 12, 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) <sup>Year)</sup> 1931 Months 1 □ M 2 🗓 F 052-26-5440 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State 1 ☐ Yes 2 ☑ No Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21060 USA 7885 Gordon Court #567 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Office Worker Healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Delbert Powell Violet Lavina Wood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7948 Central Road Pasadena, MD 21122 Ruth R. Torres/friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 08/22/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 MO125 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or s a consequence of): disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending

**Physician** /Medical Examiner Examiner

pe

P.O.

Records,

Division of Vital

Hospital or Attending

**Physician** 

/Medical

Examiner

Funeral

Director

28a-f show

Director MD

Funeral

þ

Completed

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

POWELL

CORGIANUA,

attending physician and for use as the burial-transi the signed by t if be detach been sign cate has b certificate director,

this After this funeral of

n 24 hours after death.

e Funeral Director; Aftetely filled in by the fun

within 2

Physician/Medical

à

Completed

Be

Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗷 No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

3 Suicide

one)

4 Homicide

investigation

28a. Date of Injury (Month, Day, Year)

and manner stated.

CAMMINO

29a. Certifier (Check only

TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29b. Signature and title of certifier

6 Could not be determined

29c. License number 563726

801 STING

29d. Date signed (Month, Day, Year) 8005,81,80

28f. Location (Street and Number or Rural Route Number, City or Town, State)

HINDE 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M みづき どつか いか M(

Immuns CILEM BNOORE

MD

18055

State



mo

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

**ORIGINAL** 

HUHWAY

Registrar DHMH 17 Rev 1/2001

			For State Registrar	State of Maryla		rtment of He tificate of D		ntal Hygien Reg. N	2000	3 27094		
	Physicia /Medic		1. Decedent's Name (First, Middle, I	Last)	PAST	ON		Date of Death Month Date of Death	2 2008	3. Time of Death 5.340AM		
	Examin		4a. Facility Name (If not institution, of	al of Baltin		4b. City, Town, or L Balhma	relim		c. County of Death	,		
	Funeral Director		5. Social Security Number 6.  215 - 40-5434  Usual Residence of Decedent	450 4 0 -	rs. last birthday) Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Year (LG. 6, 19	9. Birtl Co.	nplace (State or Foreign untry)		
	with the Maryland a or 28a-f show	tor	10a. State 10b. County	10c.	City, Town or Loc	ation IIMORE				10d. Inside City Limits		
ton	th with the 23a or 28a	Funeral Director	10e. Street and Number 5206 57. ()	HARLES AU	ic.	10f. Zip Code	215	10g. C	citizen of What Co	· ·		
P 21 V	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evanina must be notified at once.	þ	11. Marital Status  1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	- 1		panic Origin? (Specify Mexican, Puerto Rica Specify:	Yes or No- in, etc.)	14. Race - Ame Black, White Specify:	, etc.		
IVIN PC 21215-0036	vithin 72 hou nne. <b>han "natur</b> "	Completed	15. Decedent's (Specify only highest of the secondary (0-12)	grade completed)  College (1-4or 5+)	(Give k		ring most of working		Kind of Business/I	ndustry TE SUPERC		
	d be filed w ental Hygie ced other ti c event, th	Be	17. Father's Name (First, Middle, La		Jia	CK PUX	8. Mother's Name (Fi	rst, Middle, Maide	MARK In Surname)	<u>e7</u>		
Me Maryland	nd 2 should alth and Me 27 is mark or traumation	To	19a. Informant's Name/Relationship  MEUUIN L. Payr	(Type, Print)	19b. Mailing	<u> </u>	nd Number or Rural Ro		_	(ip Code) Md. 2/3/6		
Baltimore,	Pages 1 a nent of Her ant: If Item ury or othe		20a. Method of Disposition  1  Burial 2 Cremation 3  4 Donation 5 Other (Special Control of Control	201	o. Place of Dispos cemetery, crem.	ition (Name of	Date	20c. l	Location - City or	Town, State		
Balt	permit. Departr Importa any inji		21. Signature Duneral Service Lic	10 martie	22.	Name and Address	of Facility BEVE MOND SON	Ave- BA	CRONAL.	TIEFS nd.01223		
	Physician		23a. Catt Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	nly one cause on each line. $Scrt$	ic shoc	23	such as cardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death		
	/Medical Examiner	er	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to (or as a cons	Due to (or as a consequence of):  MRSA Sessis  Due to (or as a consequence of):							
J, 09	ate be executed hysician and the burial-transit	al Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		8 days							
P.O. Box 687		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pree  1	etal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year		
	uires that t n signed by	ρ	Part II. Other significant conditions Acute Rena			derlying cause given	in Part I.		/	the cause of death?		
Reco	The law rec ate has bee age 2 shou	Completed	Acute Respir	prior to death?	topsy findings available completion of cause of							
of Vita	ding Physician: The In. After this certificate he funeral director, page	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Inpatient 2		3 □ DOA Other:	4 Livuising Home					
Division of Vital Records,	Attending P death. ctor: After t	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not determine	t be 280 Place of Injury - At			es 2□No	Describe how injude the Location (Street a	and Number or Ru	ıral Route Number,		
Div	ospital or / hours after ineral Dire y filled in b		29a Certifier 1 Certifying	Physician: To the best of my	knowledge death	occurred at the time	data and place and	due to the cause	(s) and manner as	hateta a		
	To the He within 24 To the Fu	Medical	(Check only one) 2  Medical Example 29b. Signature and title of certifier	caminer: On the basis of exame and manner stated.	ination and/or inv	29c. License	nion, death occurred a	29d. D	nd place, and due	h, Day, Year)		
	η,		30. Name and address of person wh	no completed cause of death (I	tem 23a) (Type, P	rint)	-000	Aug	1UST 18, 2	008		
	Star Registra	te ar	(Check only one)  2 Medical Exponents  29b. Signature and title of certifier  30. Name and address of person where the second of	2008 32 Registrar's Sig	SINAI gnature	1705 PITA,	I OF BOUT	more				

DHMH 17 Rev 1/2001

			1- For Amend Items 23a,25,27,28ac	partment of Health Fer me g882 ertificate of Deal	h 889209	Mal Hyg	iene <sub>9. No.</sub> 20	08	27095				
k	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Deat Month		Year _	3. Time of Death				
	/Medic		AGNES HELEN PRADICK	T		JULY	13,	2008	3:10 A M				
7	Examin	er	4a. Facility Name (If not institution, give street and number) FRANKLIN WOODS CENTER	4b. City, Town, or Location	ion of Death		E						
- 1	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	/) If Under 1 Year If Und		8. Date of Birth	BALTIMORE  of Birth  9. Birthplace (State or Foreign						
	Director		216-16-1172 1 M 2 X 89 Yrs.	Months Days Hour	ırs Min.	NOV . 20	7,1918	Count	PA PA				
	land		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or										
	Mary a-f sho ified a	tor	MD BALTIMORE SPARRO	NS POINT		1 □ Yes							
	ith the or 28a e noti	Direc	10e. Street and Number	10f. Zip Code		10	Og. Citizen of	What Count	try?				
	s 23a	ıral	2825 LODGE FARM RD APT 421	21219	0.1.0/0		USA		1				
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give X  Year or Dates:	. Was Decedent of Hispanic If Yes, specify Cuban, Mexi 1 ☐ Yes 2 【XNo Spec		aty Yes or No- lican, etc.)		e - America ck, White, e WH					
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d 2	filed w Hygie other t	CO	8 HOM.  17. Father's Name ( <i>First, Middle, Last</i> )	EMAKER 18. Mg	lother's Name	(First, Middle, N							
Maryland	should be f and Mental I s marked of umatic eve	To Be	JOHN JOSEPH GOMBALA	SE BELK	0								
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alti	permit. Departm Importa any Inju		4 Donation 5 Other (Specify)  LAKEVIEW CEMETERY 7/19/08 SYKESVILLE  21. Signature of Fureral Service Licensee  22. Name and Address of Facility CHARLES S. ZEILER & S.										
m m	20 E # 9	9	John Journs	6224 EASTERN		BALTIMO		2122					
	Physician		23a-Part1. Enter the disease, or complications that caused the death. Do not e shock, or head ailure. List only one cause on each line.  Immediate Cause (Final disease or condition	0		respiratory arre	est,		Approximate Interval Between Onset and Death  3 months				
	/Medical Examiner		resulting in death)  Due to (\( \) as a consequence of):			1.,			several years				
		Je.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	CERTIFICATIONA	AF	EXAMINE	Several year						
	ocuted nd transit	Examiner	Sequentially list conditions, if any, leading to himiciate cause. Enter Underlying Cause (Disease or injury that initiated events  C.	M 0	OVED BY M	EDICAL							
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S,	es tha igned l	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Pa	art I.		1.12		e cause of death?				
ord	requir	ed	Right hip fracture			1 □ Ye	es 2 No	3 Prob	ably 4 □Unknown				
Division or Vital Records, P.O. Box	the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed				24a. Was ar autops perform	y ned?	prior to con death?	osy findings available inpletion of cause of 2 No				
<u> </u>	sician certifi rector	Be	25. Was case referred to medical examiner?  Hospital:	l ou		(Check only one			5002				
ō	g Physer this eral di	7: To	1 Aves 200 Inospital: 1 Inpatient 2 ER/Outpati 27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at		e 5 Reside			')				
Sion	endin ath. or: Aft	atio	2 Xaccident investigation 03/22/2008 Unknown	Work? 1 ☐ Yes 2	<b>X</b> ⊇No	Subject	t fell						
DIVIS	al or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, so building, etc. (Specify)  Home	treet, factory, office	28	Sf. Location (St. City or Town	reet and Numl , State) 282 L , Spart	er or Rura 5 Loc ows P	Route Number, ge Farm Rd Coint,MD				
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, developed and manner stated.	ath occurred at the time, date investigation, in my opinion,	te and place, a death occurre	nd due to the ca d at the time, d	ause(s) and mate and place,	anner as st and due to	ated. the cause(s)				
	within 2 To the	Me	29b. Signature and title of centifier	29c. License numbe			9d. Date signe		- 1				
	(0)		) Dega, mis	D005	51340	1	7/14	1/20	008				
			30. Name and address of person who completed cause of death (Item 23a) (Type DR. FLORENCE DEZA 9101 FRANKLIN SO		TIMORE	, MD 21	237 S	UITE :	205				
Ì	Sta Registr		31. Date filed (Month, Day, Year)  AUG 2 1 2008  32. Registrar's Signature										

Reg. No. 2008

**Physician** /Medical Examiner

Funeral Director

28a-f show event, the Medical Examiner must be notified at

**Physician** /Medical **Examiner** 

Box 68760, P.O. Division of Vital Records,

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, Ite Madical Extrait or munt be any injury or other traumatic event, Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be execute neral Director: / within 24 hours a

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Рм Joseph Daniel Robier Jr. August 19, 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 818 South Woodlynn Rd. Baltimore Essex 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) Date of Birth (Month, Day, Hours Min 12 M 2□ F Days 216 14 0570 Yrs. Feb. 7, 1921 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 818 South Woodlynn Rd. 21221 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Steel Mill 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph D. Robier Sr. ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Fennell (Daughter) 406 Katherine Avenue Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/23/2008 Oak Lawn Cemetery Baltimore, Maryland 21. SignAure of Funeral Service Licensee Bruzdziński Funeral Home P.A. lokn W 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHENOSCLENOTIC HEMMT DISEASE Due to (or as a consequence of): Sequentially list conditions Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Prostate Cancer 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No 2 X No 1 □ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) Certification: To 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 20, 2008 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) 25 MAIN STREET RESTORTION MP Loboran 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 19 ay RUTH RUDICK 2008 ear 12:06 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 05/05/1919 1 □ M 2 XF Months Days Hours Min. 217-46-1267 89 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2 No BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4730 ATRIUM COURT, #550 21117 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 ∐Yes 2 No Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No WHITE If Yes, Give Year or Dates: Specify. Specify 3 Widowed Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HARRY WOLPERT FANNY MAX 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WAYNE RUDICK / SON 17 TREMBLANT COURT LUTHERVILLE, MD 21093 20b. Place of Disposition (Name of cometery crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State BETH EL MEMORIAL PARK 8/21/2008 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Mother (Specify) WSPLC 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Funeral

Director

28a-f show

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Baltimore, Maryland 21215-0036

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Physician: The law requires that the death certificate be executed Records, Division of Vital Hospital or Attending 24 hours after death.

Funeral Director: A completely within 2

Registrar

25. Was case referred to medical examiner? 1∐Yes 2DNo

27. Manner of eath Natural 2 Accident

3 ☐ Suicide 4 Homicide

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and ress of person who completed cause of death (Item, 23a) (Type, Print) W

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 Registrar's Signature

			1 = For State Registrar	State of Marylan	ıd / I		nent of H		Mental Hy	gien Reg. N	000	0 27	000
	Physic /Medi	cal	Decedent's Name (First, Middle, Las	Andrew	М.	Scot			2. Date of De Month	eath	Pay Year 3 200	$\frac{3}{20:1}$	Death (
٥	Examine Funeral Director	ner	4a. Facility Name (If not institution, give   110 N. Central  5. Social Security Number 6. Se  253-60-1244  Usual Residence of Decedent	Avenue Apt		21 rthday) If U	Balto Under 1 Year nths Days	If Under 24 Hrs Hours Min	8. Date of Bi	rth	N/A N/A 9. E	Birthplace (State of Country) GA	or Foreign
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be Completed by Funeral Director	10a. State 10b. County	Al Avenue  12. Was Decedent Ever in U. Armed Forces?  1	.S. 16a	13. Was I If Yes 1 □ Y  Decedent's (Give kind life. DO N  Labo  D. Mailing Ad	of. Zip Code  212  Decedent of 2  specify Cuba  des 2  No  Usual Occupa of work done of OT use retired, rer  dress (Street a	spanic Origin? (cn, Mexican, Pue Specify: attion uring most of wo 18. Mother's Na Lelia	Specify Yes or No roto Rican, etc.)  orking  me (First, Middle  a Mae F  dural Route Numb	16b. , Maide OUI	Black, W Specify:  Kind of Busines en Surname) Ttene	A merican Indian, hite, etc. Black ss/Industry u	-
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tra		20a. Method of Disposition  1 Ma Burial 2 Cremation 3 Language  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licenses	Removal from State (Ki	lace o	f Disposition ry, cremator Memo 22. Nar	(Name of y or other place rial I ne and Addres	Pk 8-2	Date 23-2008 March	20c. Ra Eas	Location - City andalls st F/H	or Town, State	MD
8/60,	Physician /Medical Examiner punial-transit the prinal-transit punial-transit puni	dical Examiner											e ween Death
O. BOX 6	the death certificate y the attending physiched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   1   Unknown   2   Cast   Cast								23d. Date of o		⁄ear
ecords, P	w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions	ntributing to death but not resu	ulting ir	the underly	ing cause give	n in Part i.	1 🗆	Yes	2□ No 3★	to the cause of d	Jnknown
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DIVISION OF	To the Hospital or Attending Physician: The law within 24 burus after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	Certification: To	1								ury occurred	necify) Rural Route Numi	ber,
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(	Sta	te	30. Name and address of person who co ADA ABDVLNOVA 31. Date filed (Month, Pay, 20an) 20	ompleted cause of death (Item  600 V . W 0Lf  8 37 Registrar's Signal	6	Type, Print)		imore,		. 12			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3'30 PM 15 tugast 2008 4a. Facility Name (to ot institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Wilson Healthcar Gaithersbu Montgamera
9 (Birthplace State or Foreign
Country) Center 5. Social Security Number If Under 1 Year If Under Months Days Hours 8. Date of Birth May 19, Yaag23 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 👿 F Days 096-12-0413 85 Washington Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 301 Russell Ave. United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXXVo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mabel Atilla Stark <u>William D. Allen</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Martin Lane Alexandria, VA. 22304 Anne V. Scammon (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Aug. 20, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2008 Beltsville, MD Chesapeake Crematory

Physician /Medical Examiner

Department of Health ar Important: If item 27 is any Injury or other trauonce.

Pages

**Physician** 

/Medical

Examiner

Director

by Funeral

Completed

Be

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Funeral

Director

show

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Ith and Mental Hygid 27 is marked other traumatic event, the

and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

the burial-tran been signed by the should be detached the Hospital or Attending Physician: nours after death.

neral Director; A
filled in by the fu within 24 hours a To the Funeral I

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

Be Completed by Physician/Medical Examiner

Medical Certification: To

31. Date filed (Month, Day, Year)

AUG 2 2 2008

21. Signature of Füheral Service Licensee 22. Na M00982 933	22. Name and Address of Facility Rapp Funeral & Cremation Ser. 933 Gist Ave. Silver Spring, MD 20910							
23a. Part1. Enter the disease, of complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death					
Sequentially list conditions, if any, leading to immediate cause. Either Unuerlying Cause (Disease or injury that initiated events	b. ————————————————————————————————————							
resulting in death) Last  Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1								
Part II. Other significant conditions contributing to death but not resulting in the underland Azolemića	ying cause given in Part I.	23e. Did tobacco use contrib	ute to the cause of death?  Probably 4 □Unknown					
Hyperkalenia  24a. Was an autopsy performed?  1 yes 2000 to condeath?								
25. Was case referred to medical examiner?	26. Place of Death (C	heck only one)						
1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other	(Specify)					
2 Accident		Describe how injury occurred						
3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one)  1	curred at the time, date and place, and gation, in my opinion, death occurred a	due to the cause(s) and manr at the time, date and place, an	ner as stated. d due to the cause(s)					
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, D						
DOD59423 August 15, 2005								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print	1)	O						

DHMH 17 Rev 1/2001

State

Registrar

20 Russell 32. Registrar's Signature

			For Stete	State of Ma	aryland / Dep		lealth and I	Mental Hyg	giene	18	27100	
			Registrar  1. Decedent's Name (First, Middle,	Last)	06	Timeate of	Dealli	2. Date of Dea	th	, 0	3. Time of Death	
	Physic		TOGNER	Carrett				Month	Day	Year	IIIO A	
	/Medi Examii		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	or Location of Death	1	4c. County			
1	LAdilli	iei	BRADLEY ADULT CA			HAGERST			Washi		1	
	Funeral			. Sex 7. Ag	e (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day			lace (State or Foreign	
	Director		579-05-8817	103M 2□F	90 Yrs.	Months Days	Hours Min.	2/24/19	18		a. N.C.	
	p .		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town or t						0d. Inside City Limits	
	with the Maryland a or 28e-f show Le notified at	5								'	1 ⊠ Yes 2 □ No	
	the N	Director	Maryland  10e. Street and Number		Hagerstow				log. Citizen of V	Mhat Caus		
	with					10f. Zip Code						
	death w	era	11429 Inglewood 1		Ever in U.S. 13	Was Decedent of h			United 14 Bac		ean Indian,	
Maryland 21215-0036	or Ite	by Funeral	1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent   Armed Forces?  1 Yes 2   New Year or Dates:	10	Was Decedent of h If Yes, specify Cub 1 ☐ Yes 2X No		o Rican, etc.)		k, White, Blac	etc.	
Õ	C/ 65 L/	ted	15. Decedent's	Education	16a. Dec	edent's Usual Occur	petion		16b. Kind of Bu	ısiness/Ind	dustry	
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nd		Be (	17. Father's Name (First, Middle, La	st)			18. Mother's Nan	ne (First, Middle,	Maiden Sumam	10)		
yla	should by the Ments marked imatic e		Eddie Agustus				Evelyne	Smith				
la'	2 PE 20 PE		19a. Informant's Name/Relationship			ing Address (Street					-	
	is 1 and 2 should of Health and Meritem 27 is marke other treumatic		Rosavalier Harpe	r / Niece		Tamarack (	Ct. Virgi		_			
Baltimore,			20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3	☐Removal from State	20b. Place of Disp cemetery, cre	osition (Name or imatory or other pla	ce)	Date	20c. Location -	City or To	wn, State	
ţ	Dermit. Page Department of Important: If any injury or once.		'4 □ Donation 5 □ Other (Spe		Maryland	Veterans	8/19	/2008 C	heltenh	am, 1	Maryland	
Bal	Department Department of the partment of the p		21. Signature of heral Service Li	censee	101000	2. Name and Addre	ess of FacilityPop	e Funera	1 Homes	, P.	Α.	
	45244	$\vdash$	220 Part   Sate Widespeed or o	1. June		538 Mar1				lary1		
			23a. Part I Enter the disease, or co shock, or heart failure. List or	ny one cause on each lin	ie. Do not er	ter the mode of dyli	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death	
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68				0.								
Box	n cert andin use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		-A 10 N 0.23 U			23d. Dat	e of delive	nry	
	deatl	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at		□Ectopic pregnancy □ Other (specify) _	/ 		Mo	nth	Day Year	
P.O.	at the by th tache	Physician/Med	9 Unknown	9□ Unknown								
	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	by F	Part II. Other significent condition	contributing to death bu	it not resulting in the i	ınderiying cause gıv	en in Part I.	23e. Did tol	oacco use conti	ribute to th	ne cause of death?	
Records,	w require been sig should b	Completed by	Ancin	•				1 🗆 Ye	s 2 No	3 Prob	abiy 4 Unknown	
သွ	law re as be 2 sh	ple	Prosteli	Co will	_			24a. Was e	n 24b. V	Vere autor	psy findings available	
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of Vital	Physicien: The law this certificate has b ral director, page 2 s	Be	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only on	7			
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u	ng P fler t inera	ü	27. Mann of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time o	of 28c. Injur Wor	y at k?	28d. Describe ho	w injury occurr	ed		
Sio	Attending ir death. ector: After by the tune	cati	2 Accident investigat	bo .			Yes 2 ☐ No					
Division	tal or Att s atter d el Direct ed in by	Certification:	3 Suicide 6 Could not determine	28e. Place of Inju building, etc	iry - At home, farm, st . (Specify)	reet, factory, office		28f. Location (St City or Town		er or Rura	l Route Number,	
	To the Hospital or Attending Ph within 24 hours atter death. To the Funerel Director: Atter th completely tilled in by the tuneral	Medical	29a. Certifier 1 Certifying (Check only onle) 1 Medicel Ex	Physician: To the best of eminer: On the basis of and mariner sta	examination and/or in	h occurred at the tire vestigation, in my o	ne, date and place, pinion, death occur	and due to the carred at the time, d	ause(s) and ma ate and place, a	nner as st and due to	ated. the cause(s)	
	To t To tl	Σ	29b. Signature and title of certifier	. 17		29c. Licens	e number	2	9d. Date signed	(Month, I	Day, Year)	
			Hider	-lil		02	5625	1	Lupice	17	A ons	
	5		30. Name and address of person wh	o completed cau of de	eath (Item 23a) (Type	Print)			A	1	1	
	<b>V</b> )		Vicdene 1	+ 14557	II my	11110 K	nedice	1 centre	4 Kel	Y	unte 130	
. 5.	Sta		31. Date filed (Month, Day, Year)		r's Signature	0	1	1.	١.	10	~~~	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year AUGUST .dward 16. 2008 3:15 FM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Center Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sep + 24 1938 Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In vrs. last birthday) 100 M 2□ F Months Days Min **Director** 182-01-6174 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Modical Examinar must be notified at once. 10b. County NNK 10c. City, Town or Location 10d. Inside City Limits Be Completed by Funeral Director 1 De Yes 2 No MD Glen 10e. Street and Number 10g. Citizen of What Country? 12915 21057 USA anor 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Ho If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Handicap Handica 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jean 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robinson Kosemarie 12915 olen Arm Manor Rd 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) ctro -25-08 Livernatory. 21. Signal Fineral Service 10 22. Name and Address Facility 1232 Midvalley Dr. Jessup, PA18434 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immeriate Cause (Final disease or condition resulting in death) Physician CORONARY ARTERY DISEASE /Medical Due to (or as a consequence of) Examiner MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed CONGESTIVE HEART FAILURE been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death Day Year 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed After this certificate has funeral director, page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? Yes 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Alnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Deal 28a. Date of Injury (Month, Day, Year) After 1 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: Aft
completely filled in by the fur 1 ☐ Yes 2 No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D46356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHODROW TABASSI M.D., 7601 OSLER DRIVE TOWSON. MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

AUG 22

2008

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08-05674 Maxwell Bissell Ta	1.	t Amend State of	Print in Black Inde Maryland / Departn Zoa i per me s Certific	ent of Heal	th and Mental F	lygiene  Reg. No  2. Date of Death	200	8 27   me of Death
Physicia		Decedent's Name (First, Middle,Last)				Month Day July 24, 2008	V	150 hrs
Mes े ब Examin		Maxwell Bissell Ta		4b City	Town, or Location of Deat		c. County of Death	
, <u>)</u>		a. Facility Name (if not institution, give str 5202 Leith Road		Baltir	nore		A/DD/YYYY) 9. Birthplac	e (State or
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121 d be f lental arked	e e	19a. Informant's Name/Relationship (Typ-	e Print )	19b. Mailing Addres	ss (Street and Number of	or Rural Route Number,	, City or Town, State, Zip	Code)
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Balt permit mpor njury		21. Signa of Funeral Senior Icense	Director	State	Anatomy Boa ore, MD <u>2</u> 1	rd 655 W. 1 201	Baltimore S	treet
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of Vital Records, P.O. Box 68760, ling Physician: The law requires that the death certificate be executed.  After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit	To E	1 ✓ Yes 2 No		ER/Outpatient 3	DOA 01114 N	28d. Describe ho		
ing P After Tunerz	١	27. Manner of Death  1 XX Natural 5 Pending	28a. Date of Injury (Month, Day, Year) FOUND:	FOUND:	1 Yes 2 ✓ N	0		
ion trend death.	atic	2 Accident Pending Investigation	1.1.04 0000	1150 hrs			reet and Number or Rura	al Route Number, City
Division of Vital pital or Attending Physician: unra after death. eral Director by the funeral director filled in by the funeral director	Certification:	3 Suicide 6 Could not be determined	e		, embo banding, etc.	or Tourn Sta		
F 6 5 5	Se	4 Homicide	Trial State of the	- death conversed o	t the time date and place	and due to the cause	(s) and manner as stated	d.
Fo the Hos within 24 h		(Check only one) 2 Medical Examiner	On the basis of examination ar	nd/or investigation, i	n my opinion, death occu	rred at the time, date ar	nd place, and due to the	cause(s)
To the To the comp	Medical	29b. Signature and title of certifier	and manner stated.		29c. License number		29d. Date signed (Mont	th, Day, Year)
	2	250. Signature and the or continue	6 110		O.C.M.E.	ļ	July 25, 2008	

State Registrar

ORIGINAL

. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Russell Alexander MD.

31. Date filed (Month, Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

OCME

DHMH 17 Rev 1/2001 OCME 2006

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician Bogdanovich Trutanic ugust 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carro yKesville 710 Obrecht If Under 8. Date of Birth Nov. 4, 1917 Birthplace (State or Foreign Country) CA ecurity Number 6. Sex Age (In yrs. last birthday) **Funeral** Months 1 □ M 2**V**□ F Days Hours 569-48-2304 90 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director CA Beverly Hills Beverly Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 90212 USA 422 S. Canon Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Yes 27 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 【XNo Specify. White þ Snecify: 3 Widowed 4 □ Divorced 7 is marked other than "natural", traumatic event, the Medical Exa Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fill and Mental H Be Antoinette (Unknown) Martin Bogdanovich permit. Pages 1 and 2 sh. Department of Health and Important: If item 27 is ma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9400 W. Olympic Blvd., Beverly Hills, CA 90212 Mr. Richard S. Trutanic, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State All County Cremation 8/21/2008 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL M00764 0 PO Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eve brovascular Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Corebrovascu if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of) attending physician pe Physician/Medical the as - use IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Year Day 4□Pregnant at time of death 5 Other (specify) n signed by the a 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 arrhu No. 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown page 2 should I Completed certificate has been Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA <sup>2</sup> this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending P 4 hours after death. Funeral Director: After t After t 28c. Injury at Work? Certification: Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

within 24 hours at To the Funeral I Hospital

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division or Vital Records,

Registrar

State

one)

29b. Signature and tipe

29c. License number

29d. Date signed (Month, Day, Year)

ROGA Eldersburg MD 21784

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For Amend Item 24a Spele Fellow 15882,08	ទ <b>ុខឧ៤្ធាយសម្រា</b> Health and Certificate of Death	Mental Hygien		27104			
	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death     Month Date	ay Year	3. Time of Death			
adde e	/Medic	al	HAROLD C VINES	4b. City, Town, or Location of Dea	Month Di	C. County of Deat	5:40 AM			
1	Examin	er	4a. Facility Name (If not institution, give street and number)  VNIVERS ITY OF MD MEDICAL CEN	0 1		. County of Boat				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		S. 8 Date of Birth	9. Birt	thplace (State or Foreign			
	Director		216-82-5209 <sup>1</sup> № <sup>2□ F</sup> 46 Y	s. Months Days Hours Will	Mar 11, 1	962 Ma	untry) aryland			
	and w		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town	or Location			10d. Inside City Limits			
	Marylk f sho	-O.	MD Anne Arundel	Jessup			1 □Yes 2□No			
	the 1	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Co	ountry?			
	h with	al D	House of Correction Road	20794		USA				
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White				
36	s after	by Fu	1 AN Never Married 2 Married 1 Merried 2 Married 1 Meres 2 Married 1 Meres 2 Meres 1 Meres 2 Meres 1	1 ☐ Yes 2 No Specify:		Specify: b1	ack			
21215-0036	hour tural	ed b	15. Decedent's Education 16a. I	ecedent's Usual Occupation		Kind of Business/	/Industry			
5	in 72 n "na Medic	plet	(Specify only highest grade completed)	Give kind of work done during most of w ife. DO NOT use retired)	orking					
212	d with giene gr tha	Completed	6 0	none		none				
	tal Hy d othe	Be (	17. Father's Name (First, Middle, Last)		•	ne (First, Middle, Maiden Surname)				
Уlа	ould the marker harker	욘	Harold Vines Sr		e Hickland	T 01.1.	7: 0: 4:)			
Maryland	d 2 sh th and 7 is m traum		, , , , ,	Mailing Address (Street and Number or $11$ $ m Harvest Moon La$						
	1 and Healt tem 2		20a Method of Disposition 20b. Place of I	Disposition (Name of		Location - City or	Town, State			
E E	ages ent of nt; If ii		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 💆 Other (Specify) in State	crematory or other place)						
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Emeral Service Licensee Ronald S. Wade, Director	22. Name and Address of Facility State Anatomy Boar	rd 655 W Ra	1timore	Street			
m	Depar Impo any Ir	9.0	Xmm Clee	Baltimore, MD 212			567666			
r			23a. Part Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as card	ac or respiratory arrest,		Approximate Interval Between Onset and Death			
	Physician		Immediate Cause (Final disease or condition a. HEMORRHA	GIC SHOCK			6 HOURS			
	/Medical Examiner				CED		48 HOURS			
b	424. s.	ē	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C. C	EED		T A FINAL			
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	PERTENSION AM	COAGULO	PATHY	10 DAYS			
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8760,	icate be executed physician and s the burial-transit	dical	d END STAGE	LIVER DISEA	SE		SEVERAL YEARS			
<b>W</b>	certific ding p	/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of de	divor			
Box	death certifi e attending p d for use as	Physician/Me	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year			
P.O.	0 m	ıysi	1   Yes 2   No 9   Unknown							
رب ح	s that med b e deta	y Ph	y Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	use contribute to	to the cause of death?		
ğ	w requires that been signed to should be deta	ed k	HOPATITIS C		1 ☐ Yes	2 No 3 P	Probably 4 Onknown			
Division or Vital Records,	20 88 02	Completed by	ACUTE RENAL FAILURE		24a. Was an autopsy	prior to	utopsy findings available completion of cause of			
<u>=</u>		Com			performed? 1□ Yes 2 🔼	death?	s 2No			
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Othor	eath (Check only one)					
0		T.	examiner?  1 Yes 2 No  Hospital: 1 pripatient 2 ER/Out  27. Manner of Death  28a. Date of Injury  28b. Ti	batterit 3 DOA 4 Nursing	Home 5 Residence 28d. Describe how in		ecify)			
on	ding h. After fune	tion		me of 28c. Injury at work?  M 1 ☐ Yes 2 ☐ No		,				
Visi	Atten r deat ector by the	ifica	3 Suicide 6 Could not be 4 Homicide determined building, etc. (Specify)	n, street, factory, office	28f. Location (Street City or Town, Sta	and Number or F	Rural Route Number,			
á	tal or s afte al Dir	Certification:	4		Only of Fown, Ste					
	To the Hospital or Attending Phywithin 24 hours after death.  To the Funeral Director; After this completely filled in by the funeral di		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and							
	thin 2, the late the late the late the late the late the late late the late	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Mon	nth, Day, Year)			
<b>.</b>	N N N		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	143713018		8/9/0				
,			30. Name and ordress of person who completed cause of death (Item 23a) (1		, , , ,	-1-70				
				VERSITY OF MO MOON	n center =	2 S. GA	UIM ST.			
	Sta		31. Date filed (Month, Day, Year)							
	Regist	rar	AUG 2 2 2008 Steems St. 16	naue!						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 940 AM 8 200 8 M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Rosedale FRANKLIN SQUARE HOSPITAL CENTER Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 416945 Hours 1 □ M 2 🗷 F une 16,1933 Director ietnam Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Worldal Examinar must be mailfied at 1 ☐ Yes 2 ☑ No Director saltimore 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21237 ) nited Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, its Midfall Evan in once. 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 □Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced asiar Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) omemaker 10  $\omega$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rosedale MD 21237 Court Bao Nauyen - spouse
20a. Method of Disposition 20b. Place of Disposition (Warme of cemetery, crematory or other place)

Eyans Funeral Chapel Ap 24 2008 Forest Hill, MD

22. Name and Address of Facility

Eyans Funeral Chapel & Cremation Services

Eyans Funeral Chapel & Cremation Services

8800 Harford Rarkwille MD 21234 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pheumonia /Medical Due to (or as a consequence of): Examiner Cancel Lung Conc Due to (or as consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 10o 1 ☐ Yes 2 ☐ No 1 □Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA ္ရ this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 1 Natural 5 Pending investigation n 24 hours after where he Funeral Director: After here to the funeral by the funeral filled in b 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. To the I the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number AUGUST 21, 2008 062373

State Registrar

DHMH 17 Rev 1/2001

FRANKLIN

Square

DR

BaLTO

md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A

AUG 22

DR RoberT 31. Date filed (Month, Day, Year) Certificate of Death

Baltimore, Maryland 21215-0036

ending physician and use as the burial-trans P.O. Box 68760 signed by t Division of Vital Records, certificate illed in by the fi

1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician **AUGUST** 20 2008 5:32A M VIENTE EVELYN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CATERED LIVING OF COCKEYSVILLE COCKEYSVILLE If Under 1 Year | If Under 24 Hrs. Date of Birth Month Day, Year) 09/14/1923 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 і F 184-12-1062 84 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Exerciting Internate the notified at once. 1 Tyes 2 No Funeral Director MD BALTIMORE COCKEYSVILLE 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21030 10881 YORK ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ∐Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 🛣 No Specify: 2 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTING CLERK US GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM LEVY TDA ELKIN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1752 N.W. 126TH DRIVE, CORAL SPRINGS, FL IAN VIENTE / SON 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 2 Cremation 3 Removal from State FALLS CHURCH, VA KING DAVID CEMETERY 08/21/2008 4 □ Donation Other (Specify) 21. Signature of Funeral Service L 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, r compliming that caused to shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 No 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \textbf{X} Other (Specify) ASSISTED 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred LIVING Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 200, 2008 37573 30. Name and address of person who completed e of death (Item 23a) (Type, Print) Man 2, Dell 304 MA SI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 22 2008 Registrar

DHMH 17 Rev 1/2001

Amend Item State of Maryland Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** VIRGINIA WISE AUGUST 2008 1:20 P /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** FOREST HILL HEALTH & REHAB CENTER HARFORD FOREST HILL If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 ☐ M 2 💢 F 91 May 5, 1917 Director 218-46-2614 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Midical Examiner must be notified at MD Harford 1 ☐ Yes 2 No Forest Hill Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21050 109 Forest Valley Drive USA by Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.

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State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signat Rona T Approximate Interval Between Onset and Death 24d. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, at heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Sepses /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enier underlying Cause (Disease or injury that initiated events resulting in death) Last anne Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the sahould be detached Yes 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was a autopsy performed? After this certificate has funeral director, page 2 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Dcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID DUNN 615 W. MACPHAIL ROAD 21014 BEL AIR, MD. 31. Date filed (Month, Pay, Year) 2008 Registrar's Signature State Registrar

			1 - For amend Registrar	\$#gatepe£Mga	HY <b>68</b> 9		ar <b>yn</b> ent of f rtificate of				g. No. 2	008	2710
	Physici	an	1. Decedent's Name (First, Middle, Last)	0.	10/1	ر سرب	2			2. Date of Death Month	Dav	Year	3. Time of Death
	/Medic	al			VVZ	ALTER		-1		August	18, 200		8:30 A. M
	Examin	er	4a. Facility Name (If not institution, give s 5320 Dorsey Hall I		202		4b. City, Town, o				Howa:		
	Funeral		Social Security Number 6. Sex	7. Age		ast birthday)	If Under 1 Year	If Under	-	. Date of Birth (Month, Day,	Voarl	9. Birthpla	ace (State or Foreign
	Director		215-24-5169 <sup>1図</sup>	M 2□ F	78	Yrs.	Months Days	Hours	Min.	ec. <del>29</del> ,	1929	Mary	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	cation					100	d. Inside City Limits
	Maryl:	ō											1 □Yes 2⊠No
	r 28a	Director	MD Howard  10e. Street and Number			EIIIC	ott City 10f. Zip Code			10	g. Citizen of W	hat Countr	y?
	h with		5320 Dorsey Hall I	Orive Apt	202		210	42		1	USA		
	ems	Funeral	11. Marital Status	Was Decedent E     Armed Forces?		i. 13. \	Was Decedent of F f Yes, specify Cub	lispanic Or an, Mexicar	igin? (Speci	fy Yes or No- can, etc.)		- America	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married  3X Widowed 4 ☐ Divorced	1 Tyes 2 □ N			I∐Yes 2⊠No	Specify:		, ,	Specify:	T.Th -1 4	
5-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show fieal Examination of profits of an	edk	15. Decedent's Educ	Year or Dates: 1	950-		dent's Usual Occup	ation		1	6b. Kind of Bus	siness/Indu	ıstrv
212	hin 72 9.	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+		(Give	kind of work done DO NOT use retire	durina mos	st of working				,
21	ed with	Completed	12			Aero	Space En	ginee	r		Defen	se	
Maryland	be file	Be	17. Father's Name (First, Middle, Last)	_							laiden Surname	e)	
<u>Ş</u>	d Mer narke natic	2	Martin Otto Walter			401 14 11			-	rene Sh		01-1- 7:- 0	2-4-1
<u> </u>	id 2 sl Ith an 27 is r traur		19a. Informant's Name/Relationship (Typ.  Thomas Walter	Son		Ī.	g Address <i>(Street</i> Forest						*
ē,	f Hea f Hea item 2		20a. Method of Disposition	5011	20b. Pla		sition (Name of natory or other place		Dat		20c. Location - 0		
e E	Pages ient o nt; If i		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			ark Cemet		3/22/2	2008   1	Baltimo:	re, M	D
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, it is Marien Examination in a language.		21. Signature of Funeral Service License	1/		22	. Name and Addre	ss of Facili	tySter]	ling As	hton Sc	hwab	Witzke
<u>n</u>	e a E e		1 Sta Kel	FAlla	SA	1	uneral Ho 630 Edmor	ndson	Avenu	ie: Cat	onsvill	e, MD	21228
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	eations that caused to e cause on each line	the death. e.	. Do not ent	er the mode of dyi	ng, such as	cardiac or	respiratory arre	est,	i i	Approximate Interval Between Onset and Death
East of the second	Physician	ŕ	Immediate Cause (Final disease or condition resulting in death)	_ M	100	ARDI	AL	INF	FARC	TION	)		Unset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of):	ART	ERV		SEASI		1 3	04.
		er	Sequentially list conditions, if any leading to immediate	Due to (or as a			AKI		- 9	1/0/1/0			7.
1	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,		,							
Ď	e exec an an rrial-tr	Exa	resulting in death) Last	Due to (or as a	conseque	ence of):							
08/PU	icate be executed physician and the burial-transit	edical	<b>€</b> d.										
وَ ×	leath certificate be executed attending physician and I for use as the burial-transit		IF FEMALE:	) - If									
Ř	atter for u	Physician/M	in the past 12 months?	3c. If yes, outcome c 1 ☐ Live birth 2 4 ☐ Pregnant at	2 ☐ Fetal	death 3	Ectopic pregnand Other (specify)	у			23d. Date Mon	of deliver oth	y Day Year
j.	0 0 0	ysic	1 □Yes 2 □No 9 □ Unknown	9 Unknown	tille of de	saii SL							
". 7.	ding Physician: The law requires that the de n. After this certificate has been signed by the funeral director, page 2 should be detached	by Pr	Part II. Other significant conditions conf	0		ting in the ur	nderlying cause giv	en in Part l		23e. Did tob	acco use contri	bute to the	cause of death?
ecords,	quire; en sig uld bi			ILLATIO	N					1 □ Ye	s 2 No	3 Proba	bly 4 ☐ Unknown
ပ္ပ	law re as be 2 sho	Completed	HEART BLO	CK						24a. Was ar autopsy	24b. W	/ere autop:	sy findings available pletion of cause of
<u>r</u>	The sate h	Com								perform	ned? d	eath?	
VITAI	cian: sertific setor,	Be (	25. Was case referred to medical examiner?	2. 4						Check only one			
0	Physical direction	<u>د</u>	1 ☐ Yes 2 ☐ No ☐ Ho	ospital: 1 ☐ Inpatien 28a. Date of Injury		R/Outpatier 28b. Time of	t 3 DOA Oth	er: 4 □ Ni			nce 6 ☐ Othe		<u> </u>
5	ding h. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day,	Year)	Injury	Wor	yat k? Yes 2□		a. Describe no	w injury occurre	ea	
DIVISION	Atten r deat sctor: by the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur building, etc.	y - At hor	ņe, farm, stre		.00 =		f. Location (Str	eet and Numbe	er or Rural	Route Number,
5	tal or s afte al Dire	Certification:	4 ☐ Homicide determined	building, etc.	(Specify,	,				City or Town	, State)		
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.		29a. Certifier  (Check only  Certifying Phys  Description of the control of the c	ician: To the best of	f my know	rledge, death	occurred at the ti	me, date a	nd place, ar	nd due to the ca	ause(s) and ma	nner as sta	ated.
	the hin 24 the F	Medical	one)	and manner stat	ed.	Grid/Or (I)					· <u> </u>		
	ල් ද ද <b>ව</b>	~	29b. Signature and title of certifier	1 ~	D		29c. Licens	e number	740	) 29	od. Date signed Aリんぴくて	(Month, D	2008
	www.	4	20 Name and add a second		oth //	00=) /T	Dalan)	~ 7	, + 6	1	10001		
	18		30. Name and address of person who cor	N N	atn (Item	z3a) (Type, I SOHN	Print) S HOPK-1	WS	170551	TAL	BALTIM	YORE	MD.
	Sta		31. Date filed (Month, Day, Year)	3 Registrar	r's Signati	re /				· · · · · ·			

			State of Maryland / Dep 1 - State Amend #26, perMD g882. 8/22/08	artment of Health and N	fental Hygid	ene g. No. 2008	2710
	Ą.		Negistrar     Decedent's Name (First, Middle, Last)	rimodio or bodin	2. Date of Death		3. Time of Death
.2	Physici /Medic		Violet Mary White		August 2	21, 2008	7:52 A. M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
	No.		14313 Dairydale Road	Baldwin    If Under 1 Year   If Under 24 Hrs.	O Data of Birth	Baltimor	
ŀ	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthda) 84 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, May 10,	1924 Bal	hplace (State or Foreign untry) TIMORE, MD.
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Maryla f sho fed at	tor	Maryland Baltimore County Baldwi				1 □Yes 2 HNo
	a or 28a st be notif	Funeral Director	10e. Street and Number 14313 Dairydale Road	10f. Zip Code 21013	10	g. Citizen of What Co United St	,
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funera	11. Marital Status  1  Never Married 2 Married  3 Midowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	72 ho 'natur	Completed by	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing   1	6b. Kind of Business/	Industry
121	within ene. <b>than</b> '	Jump	Elementary/Secondary (0-12) College (1-4or 5+) 1/2 N/a	Home Maker		Own H	ome
d 2	e filled Il Hygi other vent, t	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Ma	aiden Surname)	
ylar	ould be Menta arked atic ev	To B	Joseph Frank Hill Sr.	Antoin	ette Mary	y Augustin	iak
Maryland	d 2 sho th and 7 is m traum			ing Address <i>(Street and Number or Rui</i> 13 Dairydale Road		•	
	Healt tem 2	- 3	20a. Method of Disposition 20b. Place of Disp	osition (Name of	Date 2	Oc. Location - City or	
D E	Pages nent of nt: If i			neral Chapel Augu 20	st 22,	Forest Hil	l,Maryland
Baltimore,	permit. Departm Importa any Inju		21. Signature of Funeral Service Licensee J. Jav. R.P.	2. Name and Address of Facility Paceful Alternativ 2325 York Road	es Funera Timonium,	al&Cremati ,Maryland	on Ctr.,P.A 21093
	*		23a. /ar I. Ever ne dise , or complica ons that of used the death. Do not en shrick, he in failure. List only one cause on lach line.	nter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Physician	0. 1	Immediate Cause (Final disease or condition resulting in death)	(8			Onset and Death
ALC:	/Medical Examiner		Due to (or as a consequence of):	Caille ADON			
1		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. ATRIAL 1  Due to (or as a consequence of):  C. Due to (or as a consequence of):	UBZIONIII V			
V	ecuted nd transit	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	SUSION			
8760,	ate be executed thysician and the burial-transit	E E	Due to (or as a consequence of):				
687		edical	d				
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	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ord	equire en sig ould b	ed b			1 ☐ Yes	s 2☑No 3□Pr	robably 4 Unknown
I Records,	> 0 70	Completed			24a. Was an autopsy perform	ed2   death?	utopsy findings available completion of cause of 2 No
or Vital	Physiclan: this certific ral director,	Be	25. Was case referred to medical examiner?	1	th (Check only one		
or	Physic this cral dire	L <sub>0</sub>	1		ome 5 Resider 28d. Describe hov	nce 6 Other (Spe	city)
on	Attending r death. ector: After by the fune	tion	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	of 28c. Injury at Work?  M 1 □ Yes 2 □ No	Zod. Dodolibo liov	injury occurred	
Division	I or Attendiater death. I Director: A	ertifica	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical Certification:	29a. Certifier (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, dea 2 ☐ Medical Examiner: On the basis of examination and/or and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occu	, and due to the car rred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Mont	
			· WIN/ Jasa mo	MD005865	A a	UGUST al.	2008
	5		30. Name and address of person who completed cause of death (Item 23a) (Type MALK G. SABA MD 7505 O.	SLER DRIVE SU	ITE 205	Tauson	21204
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 2 2 2008  32. Figistrar's Signature	boote			
			MUU H H LOUD JOANS				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 4 Month ugust 2000 lorence natheryn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Burnie Health+ If Under 1 Year Kehah If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign
 Country) **Funeral** Days Year) Months Pennsi 1 □ M 2 🛛 F 195-22 Director 126 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No Director lersv trunde 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USP 110 Funeral ۵ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any Injury or other traumatic event, Item Mes Elementary/Secondary (0-12) College (1-4or 5+) home Homemak 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wlinnick ပ rober + 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Buffa 20b. Place of Disposition (Name of cemetery, crematory or other place) HVE -daughter amp Date 20a. Method of Disposition

1 Burial 2 Di Cremation 3 Removal from State 20c. Location - City or Town, State Evans Funeral Chapel Billion 8 15 08 Forest Hill, MD

22. Name and A ress of Facility
Evans Funeral Chapel - Cumation Services tarkville 8 15 08 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses nous 8800 HARFORD ROAD, BALTIMORE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician omplication /Medical Due to (or s a consequence of) Examiner 1 den if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-1 Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 □ Yes 2 □ No Ö been signed by the should be detached 9 Unknown 교. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 3 Probably 4 Unknown ORONARI RTERU 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy certificate tal or Attending Physician: Tr rs after death. al Director: After this certificate ed in by the funeral director, pag 1 ☐ Yes 1 ☐ Yes 2 D No 2 No of Vital 25. Was care referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation une 27/08 4:00 AM 1 □Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State)
323 Ahern Ct., Millersvil Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 124 hours a 29a. Certifier and manner stated. the the within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 120066019

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TAMADER

BURNIE

MIRA, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2:28 AM 20 Mary Catherine White 08 3008 /Medical 4a. Facility Name (If not institution, give street and number)
God Somari Tan Hosy 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 👿 F Maryland 213-28-4951 75 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow 1 X Yes 2 □ No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itema 23a or U.S.A. 21206 6416 Rosemont Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give 1 Never Married 2 X Married 1 ☐ Yes 2X No Specify: þ Specify. If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced White natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than \* any Injury or other traumatic avent, the Mad 2008. Elementary/Secondary (0-12) College (1-4or 5+) Catholic Charities 12 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walburga Unknown Bernard Smith ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6416 Rosemont Avenue, Baltimore, MD 21206 Mr. Howard White, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/26/2008 Baltimore, Maryland Most Holy Redeemer 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Derandria 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finaf disease or condition resulting in death) **Physician** Myocardial /Medical Due to (or as a consequence of): Examiner SOLAH, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons - uence of) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 0 Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Valve 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼No 1 Ninpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After t 28c. Injury at Work? Injury 1 XNatural 5 Pending thours after death.

uneral Director: After silled in by the fur 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aff
To the Funeral D
completely filled in 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ka 29c. License number Kes - 000 07-20-M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMIR KAZORY Blud, Baltimore, MD Loch Raven

State Registrar

. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 2 2 2008

Records, P.O. Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** August Wisniewski 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hopkins TheAked Balkmore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Davs 1 □ M 2 🐼 F 72 Director 212-34-6262 March 1,1936 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Baltimore Co. Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or filed within 72 hours after death with 21224 United States 7410 Belmont Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married permit. Pages 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or i. any injury or other traumatic event, the Medical Exercises. Baltimore, Maryland 21215-0036 1 ☐ Yes 25No Specify: Specify: Completed by White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker Baltimore County 1 Year 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Kirchoff John Deickman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21224 Melanie A. Wisniewski (Daughter) 7410 Belmont Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 

⑤ ☐ Other (Specify) 8/18/2008 Baltimore, Maryland Lawn Cemetery 21. Signature of Juneral Sen 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 23a. Part 1. Enter the disease, or complications that caus +1 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Conjective lea-t /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chie to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) I□Yes 2□No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 hknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 □Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 | Yes 2 | 1 | 10 | 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled TECETIFYING Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title ef-certifie DOO 66086

State Registrar 4940 Eastern Avenue

Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

GroseKowski

ຶ 2008

Kevin

31. Date filed (Month, Day, Year) AUG 2 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	tate of Maryland / Depa	artment of Health and N	lental Hygie	2000	27113
	At <sub>e</sub>		Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physici /Medi		Opal Elizabeth We	imer		August 17	7, 2008 <sup>Year</sup>	8:00 P M
	Exami		4a. Facility Name (If not institution, give street		4b. City, Town, or Location of Death		4c. County of Death	<u></u>
	. *		Riverview Nursing Ho	me	Essex		Baltimor	е
	Funeral	Г	Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birthp	lace (State or Foreign
	Director		218-74-5324	2 🔀 F Yrs.	Months Days Hours Min.	(Month, Day, Ye	ar) Coun 1909 West	• •
	pı ,		Usual Residence of Decedent			naile III		
	rylar	_	10a. State 10b. County	10c. City, Town or Lo	cation		10	0d. Inside City Limits
	Ma-f-s	9	Maryland Baltimore	Dundalk				1 □Yes 2X No
	라 다 20 20	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Coun	try?
	after death with the Maryland or Items 23a or 28a-f show uinst must be notified at	<u></u>	7520 Holabird Avenue		21222	īīn	ited State	26
	items items	Funeral	11. Marital Status 12. V	Vas Decedent Ever in U.S. 13. Varmed Forces?	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto		14. Race - Americ Black, White, e	an Indian,
98	afte or it	F	1 Never Married 2 Married 1	□Yes 2,□No	1 □Yes ¾□No Specify:	r nouri, etc.,		ng.
21215-0036	72 hours after "natural", or ite	Completed by	3 Widowed 4 □ Divorced	ear or Dates:			Specify: Whi	ite
5	72 h 'natu	ete	15. Decedent's Educatio (Specify only highest grade cor	npleted) (Give	dent's Usual Occupation kind of work done during most of work	ing 16b	. Kind of Business/Inc	lustry
121	within ene. than'	m d		College (1-4or 5+)	OO NOT use retired)			
2	filed w Hygie ther t	ပိ	9 years	Homer	maker		Own Home	
anc.	should be filed of Mental Hygi marked other matic event, II	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, Maio	len Surname)	
χį	ould be i Mental narked o	ဥ	Benjamin F. Hennessey		Lora I.	Groves		
Maryland		16. 3	19a. Informant's Name/Relationship (Type. F	Print) 19b. Mailir	ig Address (Street and Number or Run	al Route Number, Cit	ty or Town, State, Zip	Code)
	and lealth m 27				Holabird Avenue			
ore	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1   → Burial 2 □ Cremation 3 □ Remo	20b. Place of Dispo cemetery, cren	sition (Name of Inatory or other place)	Date 20c.	. Location - City or To	wn, State
<u>=</u>	Pag men ant: ury		4 ☐ Donation 5 ☐ Other (Specify)		Mem. Gdns. 8/22/	′2008 Be	l Air, Mar	ryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau		21. Signature of Funeral Service Licensee		. Name and Address of Facility			
_	20 E 20	dia 1	Vali a lone		ıda-Ruck Funeral F 022 Wise Avenue I			
			23. Part 1. Enter the disease of complication shock, or heart failure List only one ca	ns that caused the death. Do not ent-	er the mode of dying, such as cardiac	or respiratory arrest,	<del> y</del>	Approximate Interval Between
lin.	Physician	0 1	Immediate Cause (Final disease or condition	Cardiec	A rue hadhin	190	4	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):		, , , ,		2-3400)
	Examiner		Company is a second	Suspecked a	cure myo and	ial w	anchim	un. kunn
	D +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to as a consequence of):		U		
	nd ransi	Examiner	that initiated events					
o,	an a	ŭ	resulting in death) Last	Due to (or as a consequence of):				
8760,	cate be executed ohysician and the burial-transit	dical	d					
9	ng ph as th	Jed	IS SEMALE				1	
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant	yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of delive	ery
	dea le att	icie	1 Tyes 2 TNo	☐ Pregnant at time of death 5☐	Other (specify)		Month	Day Year
P.0	that the dended by the detached	hys	9 ☐ Unkn <i>o</i> wn	Unknown				
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by F	Part II. Other significant conditions contribu	- 0-	derlying cause given in Part I.	23e. Did tobacc	o use contribute to the	e cause of death?
D	w require s been sl should b	ed	Hanelea	Demanha.		1 ☐ Yes	2 ☐ No 3 ☐ Prob	ably 4 hnknown
Records,	aw re is be 2 sho	Completed				24a. Was an	24b. Were autor	osy findings available
ď	The lav	mo				autopsy performed	?/ death?	npletion of cause of
ta	iclan: The certificate ector, pag	0	25. Was case referred to medical		26 Plans of Danti	1 ☐ Yes 2 🗹 n (Check only one)	No   1 ∐ Yes	2 □No
of Vital	Physician: r this certificanal director, p	To B	examiner? 1 ☐ Yes 2 ☐ No Hospit	al: 1 ☐ Inpatient 2 ☐ ER/Outpatien	0.0		6 ☐Other (Specify	
0	ding Phy h. After thi funeral	r.		la. Date of Injury 28b. Time of		28d. Describe how in		<u>//</u>
lo	ndin th. :: Aft	tio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division	Atter	ij	a Doutside 6 D Could not be	e. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Street	and Number or Rura	l Route Number.
<u>S</u>	after after d in t	Certification:	4 Homicide determined	building, etc. (Specify)		City or Town, St	ate)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	spita nours neral		29a. Certifier 1 Certifying Physician	n: To the best of my knowledge, death	occurred at the time, date and place.	and due to the cause	e(s) and manner as s	tated.
	e Ho e Fu letely	Medical	Check only 2 Medical Examiner:	On the basis of examination and/or invind manner stated.	vestigation, in my opinion, death occurr	red at the time, date	and place, and due to	the cause(s)
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funera	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, I	Day, Year)
	/		Ma MO		D-3875	4 0.	8-18-3	2008
	Y		30. Name and address of person who comple	ted cause of death (Item 23a) (Time It	Print)	,		
1	5		MALIKA WASE	BM. 709. B	ASTERN BL	LVD, N	1-D -21:	221.
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 2 2008	2. Registrar's Signature	W			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-06131 State of Maryland / Department of Health and Mental Hygiene **Bobby Baggotts** Certificate of Death . 1- For State Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day August 11, 2008 Physician/ 0758 hrs Bobby Baggotts Medical Examiner c County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Southern Maryland Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. If Under 1 Year 5. Social Security Number Age (in yrs. last birthday) Country) Funeral Min Months Days Hours Washington, DC 6/16/1951 Director 578-68-1725 1 XM 2 F 57 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 X Yes 2 No 23a or 28a-f show notified at once, Upper Marlboro MD Prince George's Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 20772 United States 8900 Fairhaven Avenue 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No Funeral 12. Was Decedent Ever in U.S 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces Never Married 2 Married 2 X No Yes Specify: Black Yes 2 X No specify: If Yes, Give Year 4 X Divorced .δ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours; nent of Health and Mental Hygiene. 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) than injury or other traumatic event, the Medical Government Senior Computer Operator 12 18.Mother's Name (First, Middle, Maiden Surname) If item 27 is marked other 17. Father's Name (First, Middle, Last) Ella Bell Willis Carroll Phillips Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2 2707 Ft. Baker Dr. Washington DC B Palmer/Ex-Spouse Jacqueline 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a Method of Disposition Baltimore, crematory or other place) 1 X X Burial 2 Cremation 3 Removal from State 8-21-08 Olivet Cemetery Washington DC Mt. Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 22. Name and Address of Facility

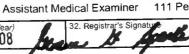
Pope Funeral Home 2617 Penn Ave SE DC 20020 alon 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line Death /Medical a Cocaine & heroin intoxication Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last AMENDED 23a, 27, 28a-f, perME, g88 28/26/08 TT Physician/Medical XUNPENDED attending physician or use as the burial that the death certificate be 23d. Date of delivery Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy Month Day Year 23b. Was decedent pregnant in the past 12 months? Live birth Fetal death Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown q Unknown signed by the be detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 V Unknown Š Records, P. Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? The law this certificate has director, page 2 sh 1 🗸 Yes ✓ Yes 2 26 Place of Death (Check only one) Physician: 25. Was case referred to medical **Division of Vital** Be Other<sub>4</sub> examiner? Residence 6 Other Inpatient 2 FR/Outpatient 3 DOA Nursing Home 5 1 V Yes ٩ 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Certification: 1 Yes 2X No unk Natural Pending 8/11/08 Director: d in by the f Fnd 6:45am 28f. Location (Street and Number or Rural Route Number, City 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 8900 Fairview Ave Upper Marlboro, MD Could not be 3 Suicide found in a building determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Wilder Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 12, 2008 O.C.M.E.

CR

State 31. Date filed (Month, Day, Year, Registrar AUG 1 5 2008

Carol Allan, MD



30. Name and address of person who completed cause of death (Item 23a)

**OCME** 

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 4:37p Robert Noland Basler Aug. 3 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Long View Nursing Home Manchester Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F 91 214-09-4863 Director 3/16/1917 MD. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. or If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD. Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4321 Hampshire Road 21074 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 🏖 📆 No þ Specify: white 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) dairy farmer agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ira Jacob Basler Rosie Lowe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) son R. Davidson Basler, 4321 Hampshire Road, Hampstead, Md. 21074 Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once, John's Leisters 4 ☐ Donation 5 ☐ Other (Specify) Westminster, Md. 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Ligensee) MO0741 lau 934 S. Main St., Hampstead, Md. 21074 L Denmer Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** mas disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: After this

nours after death.

neral Director: After this
filled in by the funeral d

within 24 hours a

To the Funeral C

completely filled WIL 5

State

Medical

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

6 ☐ Could not be

determined

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

Manchester

28f. Location (Street and Number or Rural Route Number, City or Town, State)

cause of death (Item 23a) (Type, Print)

Middle 31. Date filed (Month, Day,

and manner stated.

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Ye al Month 07 Physician 26 1546 Lucy Marie Broadwater /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WMHS - BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 🕱 F 220-52-7658 68 **Director** Virginia April 01, 1940 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f shot other traumatic event, the "highest Examiner must be notified at 1 MYes 2 □ No Director Maryland Garrett Friendsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 702 Morris Avenue Funeral 21531-2126 U.S.A Pages 1 and 2 should be filed within 72 hours after death vinent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 No Specify: 2 Specify: 3 ₩ Widowed 4 □ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Seldon Lamb Nancy B. Dodson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21536-Nancy Broadwater daughter Maryland Grantsville 175 Meadow View Dr, Apt C 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State **Cumberland Crematory** July 30, 2008 Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service L Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final myo coli. cut **Physician** Louis disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner sconmy Arten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Examiner The law requires that the death certificate be executed Atter this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Day Month Year 1 ☐ Yes 2 🗷 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ★nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ Alo Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1√10 1 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Maprier of Death 28c. Injury at Work? Natural 5 ☐ Pending investigation ne Hospital or Attendii n 24 hours after death. te Funeral Director: A bletely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2212 44 Name and address of person who completed cause of death (Item 23a) (Type, Print) Broadwa

State Registrar lan

3 0 2008

31. Date filed (Month, Day, Year,

DHMH 17 Rev 1/2001

Registrar's Signature

Amended Part II, nls, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per phy., 07/30/08, State of Maryland / Department of Health and Mental Hygiene [] [] | Allegany Co.1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 07 **Physician** ELEANOR BRIDGES 242008 1505 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 85 Director 218-16-2907 MAR. 9,1923 MARYLAND Usual Residence of Decedent 10a. State 10c. City. Town or Location 28a-f show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, I'm "modeal Exerciting to ast be rediffed at Director 1 ☐ Yes 2 X No MD ALLEGANY CRESAPTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13812 FLORIDA AVENUE 21502 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME th and Mental Hygien 7 is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RALPH B. SKELLEY LULA MAE LEASE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 13812 FLORIDA AVENUE, CRESAPTOWN, MD RITA WOODWARD / DAUGHTER other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 b permit. Pages Department of Important: If It any injury or c 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) AMBROSE CEMETERY 07/28/2008 CRESAPTOWN, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licen UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502 23a. Part 1. Enter the di ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) neumoni /Medical Due to (or as a consequence of): Examiner 201 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit 0 resulting in death) Last Due to (or as a consequence of) physician the burial Box 68760. Completed by Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached to P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Hospital 24 hours a 29a. Certifier 1🖆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 7/28/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THE

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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Mayromotis:MD

904 Seton Dave Cumberland, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician 2008 11:02 PM 17, July CONWAY /Medical MARIE HAZEL 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🙀 F 79 **Director** <del>214-30-2082</del> 1/9/29 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. In 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Mudical Evantions must be redtified at Director 1 ¥Yes 2 □ No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 714 Northside Dr. 21701 US 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 ₩ Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker homemak i ng 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Ruth Marlow Mitchell O. Gates မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i permit. Pages 1 and Department of Healt Important: If item 27 any injury or other tone 2 714 Northside Dr., Frederick, MD 21701 <u> Marie E. Conway – daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) White Rose LLC 7/22/08 York, PA and Address of Facility 21. Signature of Funeral Service Licenses Workinger-Semmel F.H. & Crematorium, Inc. Market St., York, PA 17403 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause operach line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic **Physician** gus disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to humediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a considering of or Attending Physician: The law requires that the death certificate be executed Box 68760/5/ that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 ☐ Unknown4 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2X No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **X**No 1 ☐ Yes 2[ 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Iniury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital e Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. within 2 29b. Signature any d cause of death (Item 23a) (Type, Print) 30. Name and address of person who

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State

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31. Date filed (Month, Day, Year)

AUG 2 2 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month George Edward Chenoweth, Sr. Aug. 4 2008 2:26a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dove House Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ★ M 2 □ F 72 Director 216-32-6967 11/24/1935 MD. Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural" or hame 93a or 90a. to ham. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f shov edical Examiner must be notified at Director MD Carroll 1 ☐ Yes 2 ☐ No Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3317 Kensington Square 21102 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. I∏Yes 2⊠XNo fYes, Give Year or Dates: 1 □ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 warehouseman Howard Johnson's 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joshua Gent Chenoweth, Sr. Gladys Irene Auts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh
Department of Health and
Important: If item 27 is m
any injury or other traum Teresa M. Chenoweth, wife 3317 Kensington Square, Manchester, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 8/8/2008 Hampstead, Md. 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee M60723 934 S. Main Street, Hampstead, 21074 Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final anun Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an . Were autopsy findings available prior to completion of cause of has autopsy performed death? 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2No Other: 4 Nursing Home 5 Residence 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this 6 Other (Specify) 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ∏Yes 2 ∏No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled ir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signatur

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death (Item 23a) (Type, Print)

strar's Signature

State Registrar 30. No

me and address of derson who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2000 **Physician** 0837 M Sandra Kay Davis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2306 Hel No TIRIKE Clse If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Washington, DC 8. Date of Birth (Month, Day, Year) 07/15/1949 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 ☐ F Hours Months Days 217-64-8966 59 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a l'actical Evarrinar must be notified at once. 1 ☐ Yes 2 No Director Maryland Prince George's Temple Hills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 2306 Olson Street 20748 United States 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) James P. Davis Mable Parrish ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James P. Davis/Father 2306 Olson Street, Temple Hills, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cemetery 08/18/2008 | Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funy at S 22. Name and Address of Facility George P. Kalas Funeral Home, PA 6160 Oxon Hill Road, Oxon Hill, MD 20745 20 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final GASTreintes Tinal **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for es a consecuence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month signed by the a Division of Vital Records, P.O. ☐Yes 2☐No 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown cate has been si page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 □Yes 2 □No 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1☐Yes 2☐No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After t 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

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Year

SALVA der 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9. Registrar's Signature

Physician	
/Medical	
Examiner	

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be added.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 5

Division or Vital Records, P.O. Box 68760,

nus State

	- State Registrar			Cer	tificate of i	Death		R	eg. No.	900	- I 1	\$.a. 00
	1. Decedent's Name (First, Middle	e, Last)						2. Date of Deat			3. Time of D	Death
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cal	4a. Facility Name (If not institution											
ner	417½ N. Centr		ilibel)		4b. City, Town, or Location of Death 4c. Cour  Cumberland							
			7								gany	
	5. Social Security Number	6. Sex 1 ☐ M 2 【X】F	7. Age (In yrs.		If Under 1 Year Months Days	If Under Hours	Min.	<ol><li>Date of Birth (Month, Day,</li></ol>	Year)	9. Birth	nplace (State or untry)	Foreign
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]	Usual Residence of Decedent		145 00									
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b	3 X Widowed 4 Divorced	If Yes, Gi Year or D	ve	1	☐ Yes 2X No	Specify:			Spe	ecify:	n_ 4 & _	
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Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)			"			D	4		
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Be	17. Father's Name (First, Middle,							(First, Middle, M		,		
2	Thomas	Anthony	7	Lebeck		ET	izabe	eth Ma	ıry	Offen	bacher	
	19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailin	g Address (Street a	and Numbe	er or Rural	Route Number	City or To	wn, State, Zi	ip Code)	
	Nancy Commare	/ Niece		55 M	aple Land	e, Ri	dgele	ey, WV	26753	3		
	20a. Method of Disposition				ition (Name of		Da	ite	20c. Location	on - City or T	own, State	
	1 🕅 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S				atory or other place & Paul		07/28	8/2008	Cumb	erland	MD.	
	21. Signature of Funeral Service											0
		Mary	~		Name and Address							• A •
Н	July 1	Culi	20		04 Decat					, MD	21502	
	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on e	aused the death ach line.	Do not ente	r the mode of dyin	g, such as	cardiac or	respiratory arre	est,		Approximate Interval Between	en
	Immediate Cause (Final disease or condition	Exs	anguina	tion						1	Onset and De	eath
	resulting in death)	u.	(or as a consequ								<del></del> -	
		. Rup	ture of	Varico	se Veins							
e e	Sequentially list conditions, if any leading to immediate		or as a consequ									
盲	cause. Enter Underlying Cause (Disease or injury											
×a	that initiated events resulting in death) Last	C. Due to	or as a consequ	uence of):								
a E		•		·								
/Medical Examiner		d										
Me	IF FEMALE:									1		
	23b. Was decedent pregnant in the past 12 months?		come pf pregna pirth 2  Feta		Ectopic pregnancy					Date of deliv	,	
sici	1 ☐ Yes 2 ☑ No		ant at time of de		Other (specify)					Month	Day Ye	ar
ج	9 □ Unknown*											
Completed by Physiciar	Part II. Other significant condition			ılting in the un	derlying cause give	en in Part I.		23e. Did tob	acco use c	ontribute to	the cause of dea	ath?
P	Congestiv	e Heart F	ailure					1 ☐ Ye	s 2 No	o 3 ☐ Pro	bably 4 <b>∑</b> Un	known
lete								240 18/00 00		Ib. 147		-71-1-1
ם								24a. Was ar autops	/	prior to co	opsy findings av ompletion of cau	se of
8								perform 1 Yes 2	<b>K</b> No	death? 1 ☐ Yes	2 No	
Be	25. Was case referred to medical examiner?						of Death	Check only one	)			
	1 X Yes 2 No	Hospital: 1 □ I	npatient 2 🔲	ER/Outpatient	3□ DOA Othe	r: 4 □ Nui	rsing Hom	e 5 🏋 Reside	nce 6 🗆	Other (Speci	ify)	
Ë	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date	of Injury th, Day Year)	28b. Time of Injury	28c. Injury Work	at	28 F	d. Describe ho	w injury occ	curred Mo	ther fel	ll on
atic	1 ☐ Natural 5 ☐ Pending 2 ☑ Accident investig	9		Unk.		Yes 2 XI	No   1	eet cau eading	to va	ricos	lar dama e veins	age
3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rura City or Town, State)										er.		
er	4   Homicide		ng, etc. ( <i>Specit</i> y nknown	")					. State) nown			
2	29a. Certifier 1 ☐ Certifying	g Physician: To the		wledge, death	occurred at the tim	ne date an	nd place as			mannar ac	ctotod	
dica	(Check only 2 Medical I	Examiner: On the ba	asis of examinat ner stated.	ion and/or inv	estigation, in my o	pinion, dea	th occurre	d at the time, da	ate and plac	ce, and due	to the cause(s)	
Medical Certification: To	29b. Signature and title of certifier	2	ioi siateu.		29c. License	numbor		00	Id Date -/-	mod /##//	Day Vac 1	
		// /= '	1					28		ned (Month,		
	1 (Oe)	fre				09157			July	7 26,	2008	
	30. Name and address of person	who completed caus	e of death (Item	23a) (Type, P	rint)			WD 0:-				
	Paul Snow,	M.D., 12	24 W. Th	ird St	reet, Cu	mberl	and,	MD 215	02			
te	31. Date filed (Month, Day, Year)	32. R	egistrar's Signat	ture					-			

Registrar

JUL 2 9 2008

Physician /Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

**Physician** 

/Medical

**Examiner** 

10a. State

**Funeral** 

Director

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ral", or Items 23a or Examiner must be r

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alth and Mental Hygid 27 Is marked other r traumatic event, the

Department of Health a Important: if item 27 Is any Injury or other traconce.

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Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlansit completely filled in by the funeral director, page 2 should be detached for use as the burlansit Be Completed by Physician/Medical Medical Certification: To

Division or Vital Records, P.O. Box 68760

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	frank, leading to immediate Due to (or as a consequence of).  Cause. Enter Underlying  Cause (Disease or injury that initiated events								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 □Ectopic			23d. Date of delivery Month Day	y Year			
Part II. Other significant conditions con  GIF (2) GII  Di Veyli cus  Part II. Other significant conditions con	3 DND	ulting in the underlying	ause given in Part I.  An armie  al mulm'h	23e. Did tobacc  Yes  24a. Was an autopsy performed'  1 Yes	24b. Were autopsy prior to comple death?	y 4 Unknown findings available etion of cause of			
25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3 1	Q45	eath (Check only one) Home 5  Residence	6 □Other (Specify)				
27. Manner of Death Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in					
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office	28f. Location (Street City or Town, St	and Number or Rural Ro ate)	oute Number,			
29a. Certifier Check only one) Certifying Physical Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death occurre tion and/or investigati	ed at the time, date and place on, in my opinion, death occ	ce, and due to the cause curred at the time, date	e(s) and manner as state and place, and due to the	d. e cause(s)			
29b. Signature and title of certifier		2	9c. License number	29d. [	Date signed (Month, Day	v. Year)			

DHMH 17 Rev 1/2001

State Registrar

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UNION HOSPITAL

EXILTON MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

NAMITA

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month **JOSEPH** JULY 26. FRANKLIN FORBECK 2008 1923 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Allegany** Memorial Hospital Cumberland 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. Months Days Hours 11☑M 2□F 87 07/27/1920 220-10-8991 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h County 1 Yes 2 No MD Allegany Cumberland 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 701 Furnace Street, Apt 217 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Force 1 Yes 2 ☐ If Yes, Give Year or Dates: 2□No 1 ☐ Never Married 2 Narried 1 ☐ Yes 2 ☑ No Specify Specify. 3 ☐ Widowed 4 ☐ Divorced WWII White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5 Street Department Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Forbeck Margaret Robey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. Forbeck / Wife 701 Furnace Street, Apt 217, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/30/2008 Hermon Cemetery Cumberland. MD 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 Approximate 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. terval Between nset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide

Box 68760, certificate be P.0. Division or Vital Records, al or Attend after death. I Director: /

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

ral", or items 23a or 28a-f shov Examiner must be notified at

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other traumatic event, the Medical

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Certification:

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(Check only one)

29b. Signature and title of certifier

30. Name and address of per

29a. Certifier

State Registrar

31. Date filed (Month, Day, Year) JUL 2 9 2008

determined

LALKINS, M.D. MEMORIAL HOSPITAL MEDICAL BIDG . Registrar's Signature me

on who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D54411

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Cumberland, MD

21502

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 7 2008

32 Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2008 08 us7 EDWARD FRANKLIN HUMPHREYS 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death HICOMICO If Under 1 Year Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Months Days Hours Min. 1 XM 2 ☐ F 218-34-9678 1935 Maryland Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2√∑ No Maryland 0e. Street and Number Crisfield Somerset 10f. Zip Code 10g. Citizen of What Country? 21817 USA 3423 Somerset Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes 2 □ No 1953-If Yes, Give Year or Dates: 1955 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Eastern Correctional Elementary/Secondary (0-12) College (1-4or 5+) Institution Dietary Officer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lola Wharton Edward Humphreys 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> 3423 Somerset Avenue - Crisfield, Maryland 21817</u> Myrna Humphreys (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug. 11, 2008 Crisfield , Maryland ridge Memorial Park 21. Signature of Funeral Service Liceasse Mary Both Bradshaw-Pruitt 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 West Main Street - Crisfield, Maryland 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ADENOCARCINOMA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably 25. Was case referred to medical examiner? 1 Yes 2 ∏ Xo Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ D Date of Injury (Month, Day, Year)

**Physician** /Medical Examiner The law requires that the death certificate be executed

**Physician** 

Examiner

**Funeral** 

Director

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Director

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Department of Health and Mental Hygiene. Important; If Item 27 Is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, Iro Medical Examiner must be mothed at

Maryland 21215-0036

Baltimore,

Box 68760

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Records.

Division of Vital

Hospital or Attending

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burial-transit attending physician the for ģ signed I page 2 should has been certificate director, this

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Physician/Medical þ Completed Be Certification: To

Part II. Ot

27. Manner of Death

1 Natural

2 Accident

4 ☐ Homicide

3 Suicide

29a. Certifier

To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A State

Jnknown	9 □ Unknown	
ner significant cond	litions contributing to death but no	of resulting in the underlying cause given in Part
CUTE	RENAL	FAILURE

			217-12-22-22-22-2	24a. Was an autopsy performed?  1 □ Yes 2 □ No 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No 1 □ Yes 2 □ No 1 □ Yes			
ed to medical			26. Place of Dea	th (Check only one)			
46	Hospital: 1 Inpatient 2 □	ER/Outpatient 3 DC	OA Other: 4 Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)			
5 ☐ Pending investigation		28b. Time of 2 Injury M	8c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred			
6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory	r, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
12 Certifying Ph	ysician: To the best of my kno	owledge, death occurred	at the time, date and place	e, and due to the cause(s) and manner as stated.			

	(Check only 2 Medical Examiner one)	r: On the basis of examination and/or invest and manner stated.	igation, in my	y opinion, death occurred a	at the time, date and plac	e, and due to the cause(s)
į	29b. Signature and title of certifier	,	29c. Licer	nse number	29d. Date sig	ned (Month, Day, Year)
	* Williams	mari MD		60515	8/0	2/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amended #19b, n1s, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08/08/08, Allegany Co. State of Maryland / Department of Health and Mental Hygiene o 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** М THOMAS PATRICK HANSEL 2008 0925 August 03, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **ALLEGANY** WMHS MEMORIAL CAMPUS CUMBERLAND | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | SEPT • 6, 1918 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** NORTH DAKOTA 89 Yrs 502-10-0015 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
Instit If Item 27 is marked other than "natural", or Items 23a or 28a-f show mixt If Item 27 is marked other than "natural", or Items 23a or 28a-f show my or other traumatic event, the Medical Examiner must be notified at my or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No **CUMBERLAND** Director ALLEGANY MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21502 **#1 BALTIMORE STREET** Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: þ WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION STRUCTURAL STEEL WELDER 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be IVA ELIZABETH PATTERSON JOHN OSCAR HANSEL မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21555 19a. Informant's Name/Relationship (Type. Print) 13905 CRESAP MILL ROAD, S.E., OLDTOWN, MD -21502permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other troonce. GEMMA SCHADE / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 08/06/2008 FLINTSTONE, MD MSVC-ROCKY GAP 2. Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A.
202 GREENE ST., CUMBERLAND, 21. Signature of Funeral Service Lic asee RUU 21502 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform certificate 1□ Yes 2☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 2 ER/Outpatient 3 DOA 1 🗌 Yes 1 🔲 Inpatient P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 29a. Certifier dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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924 Seton Drive, Cumberland, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Vik Poonai, M.D.

31. Date filed (Month, Day, Year)

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6, 2008

AUGUST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year DIANE 08 02 80 /Medical JAMES 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) 1 □ M 2 1 F 53 Yrs **Director** 218-68-4164 November 17, 1954 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Exactions trust be notified at Director 1 Yes 2 ☐ No Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 Barnard Street Funeral 21532-U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black. White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by Specify Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) caregiver geriatrics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph E. James Virginia K. Anderson ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 any Injury or other tr Susan Orndorff 21502sister 20 John's Lane Maryland LaVale 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State August 05, 2008 **Cumberland Crematory** Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 olu 1 23a. Pay . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SUDDEN CARDIAC DEATH disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner OROWAKY Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of) P.O. Box 68760 physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) nis certificate has been signed by the director, page 2 should be detached 1 ☐ Yes 2 No 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy released 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: NZYes 2 No Certification: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA hours after death.

neral Director: After this
y filled in by the funeral di this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Ca 29a Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26907

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HARJIT

AUG 0 4 2008

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

Walsh Road, Cumberland, MD 21502

Bishop

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 Physician 7, Donald Eugene Jewell 3:55 A M August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WMHS-Braddock Campus Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 □ F 234-40-3299 Director 80 West Virginia 06/26/1928 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No MD Allegany Cresaptown Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12608 Valley View Avenue 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 XYes 2 No 1948 If Yes, Give Year or Dates: 1952 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. ş 3 Widowed 4 □ Divorced 1952 White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Electrician</u> Union 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Alexander Jewell Marv Elizabeth Graves 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maeda Krizmencic / Daughter 840 Locust Street, Denver, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buria! 2 X Cremation 3 ☐ Removal from State Cumberland Crematory: 08/08/2008 4 □ Donation 5 □ Other (Specify) Cumberland, MD 21. Signature of Funeral Service Ligen 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Duer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5 days Acute Renal Failure /Medical Due to (or as a consequence of): Examiner Renal Tubular Necrosis 5 days Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consecuence of: The law requires that the death certificate be executed Renal Hypoperfusion 5 days burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by pe Chronic Renal Failure 1 X Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an <u>Congestive Heart Failure</u> 2 X No 1□ Yes Emphysema Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending Investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 1🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2. and manner stated. 29b. Signature and title confidence 29c. License number 29d. Date signed (Month, Day, Year) D33417 August 7, 2008 lot 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James R. Moen, M.D., 1068 National Highway, LaVale, MD nes

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 8 2008

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 12:00 August 01 Alic Berkley King /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1877 Old Westminster Pike Finksburg Carroll If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours Min 1 3M 2 F Yrs. Director 231-22-5765 82 Nov 14 1925 VA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ Kid MD Carroll Director Finksburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1877 Old Westminster Pike 21048 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify. WII þ 3 Widowed 4 Divorced White Year or Dates: Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker Construction 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) William Jonas King 2 Florence Clark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda King/wife 1877 Old Westminster Pike Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 08/07/2008 1X Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial Gardens Finksburg, MD 21. Signature of Funeral Service Licenses 2Printes A Penerally Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau it is each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ue /Medical o (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) been signed by the should be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No page 2 autopsy performe 1☐ Yes 20 or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Mann Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 \_Matural 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature nd title of certifier

State Registrar

DHMH 17 Rev 1/2001

WIL

**ORIGINAL** 

proof Westernister, MD2115

completed cause of death (Item 23a) (Type, Print)

		<ol> <li>Decedent's Name (First, M.</li> </ol>	iddle, Last)					2. Date of Death			3. Time of Death		
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ledic		Linda B 44a. Facility Name (If not institu				Alt Olf Town	al coding of Door				2.05 F		
amin	ier			iber)			or Location of Deat		4c. County of Death				
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eral		5. Social Security Number	6. Sex 1 □ M 2 ፲ F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 9. Birthplace (State or Foreign				
ctor		524-68-0686		59	Yrs.			Aug 27,	1948	CO	,,		
		Usual Residence of Decedent											
7	_	10a. State 10b. Cou	nty	10c. Cit	ty, Town or Lo	cation				10	d. Inside City Limits		
) E	양	MD Mont	gomery		(	Gaithers	ourg				1 □Yes 2 X No		
E C	Director	10e. Street and Number				10f. Zip Code	<del></del>	10	g. Citizen of \	What Count	ry?		
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eve	To Be (	17. Father's Name (First, Midd	. ,					ne (First, Middle, M		ne)			
atic		Robert Bartle	ett				Bev	erly Beck	:				
Ë		19a. Informant's Name/Relation	onship (Type. Print)		19b. Mailin	g Address (Street	and Number or R	ural Route Number,	City or Town,	State, Zip (	Code)		
		Wesley M. Lir	ndamood/Son		3613	24th Sti	reet.N.E.	Washingt	on . I	C 200	18		
		20a. Method of Disposition		20b. F					0c. Location -				
injury or other traumatic event, the findical Exp., the trained at E.		1 ☐ Burial 2 ☐ Crematic		State Met	cemetery, cren ropoli	sition (Name of natory or other place tan	Jul	$\chi_8^{25},  _A$	1 0 2 2 0 0 1	nia I	Timoinio		
2		4 □ Donation 5 □ Other			Cremat	ory	20	08 <sup>-3</sup> , A	rexand	ria, \	Virginia		
any		21. Signature of Funeral Serv	ice Licenseo		I _	. Name and Addre 2Vol Fune		10 Fact	Door	Dark	Drive		
U		1 Racy 1/2	Jul							)877 <u>~</u>	DIIVE		
		DeVol Funeral Home, 10 East Deer Park Driv  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval B interval B											
ian		Immediate Cause (Final disease or condition	. 4		Onset and Death								
cal		resulting in death)	a. Due to (	or as a consequ	uence of):	all	riar	1000	6) 1	-			
ner			A	therosc	leroti	c Cardio	vascular	Disease					
	ē	Se uentially list conditions	b. —	or as a consequ				-	4 -				
<u></u>	Ē	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>*</b>	or as a consequ	derice oi).		0	1	MINER				
1	Examiner	that initiated events resulting in death) Last	C	or as a consequ			$\sim$ $\downarrow$ $\wedge$	A MEDICAL EX	Alvins				
<u> </u>	=	<b>3</b>	Due to (6	or as a consequ	uerice or):	_	TIFICATION TOPRI	OVED BY MEDICAL EX					
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8	Ne l	IF FEMALE:								1			
2	7	23b. Was decedent pregnant	23c. If yes, outo	ome of pregna		Ectopic pregnanc			23d. Da	te of deliver	у		
2	ic.	in the past 12 months? 1 ☐ Yes 2 █No	4 ☐ Pregn	ant at time of c		Other (specify)	у		Mo	onth E	Day Year		
	Physi	9 Unknown	9 □ Unkno	own									
5	<u>a</u>	Part II. Other significant cond	ditions contributing to de	ath but not resu	ulting in the un	derlying cause giv	en in Part I.	23e. Did toba	cco use cont	ribute to the	cause of death?		
	d by							1 □ Yes	2 □ No	3 □ Proba	ibly 4 🗷 Unknown		
	ete												
i	횰							24a. Was an autopsy	24b.	Were autopa	sy findings available pletion of cause of		
	Completed							perform 1 □ Yes 2	ed?	death? 1 □ Yes 2			
	Be (	25. Was case referred to med	ical				26. Place of Dea	ath (Check only one					
		examiner? 1A Yes <del>2 N</del> o	Hospital: 1 ☐ Ir	patient 2	ER/Outpatien	t 3□ DOA Oth		lome 5 Resider		er (Speciful			
	Certification; To	27. Manner of Death	28a. Date o	finjury	28b. Time of	28c. Injur	v at	28d. Describe how					
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	ica	3 ☐ Suicide 6 ☐ Cou	ild not be	of Injury - At ho	ome farm etro	et, factory, office		20f Location (Ct-		0/	D. I. Marchael		
	Ħ	4 ☐ Homicide dete	ermined 286. Flade to	g, etc. (Specif	y) (10.111, 5tt	ot, lactory, critico		28f. Location (Stre City or Town,	State)	ei oi nuiai	noute Number,		
	ŭ	200 Contifies 4 P O W						1					
	Medical	Check only 2 Medic	fylng Physician: To the local Examiner: On the ba	sis of examina	wiedge, death	occurred at the ti- restigation, in my o	me, date and place ppinion, death occu	e, and due to the ca urred at the time. da	use(s) and make and place	anner as sta and due to t	ated. the cause(s)		
	73	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	e		and mann	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									
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	Med	29b. Signature and title of cert 30. Name and address of pers	on who completed cause		23a) (Type, F	D. 97	0129	3 NG	7/2	24/	o 8		
Stat		29b. Signature and title of cert	on who completed cause or, M.D., 21		n 23a) (Type, F Matthe	Print) ews Stree	0129	3 NG	7/2	24/	o 8		
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Month Year **Physician** 10:30 A<sup>M</sup> 04, 2008 August Dorothy Lissau /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Severna Park 109 Lockleven Drive If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Months Days **Funeral** 1 □ M 2 🕱 F 78 June 19,1930 Maryland 218-24-6535 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County r 28a-f show notified at 10a State 1 ☐ Yes 2X No Severna Park Anne Arundel MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a or iner must be n USA 21146 109 Lockleven Drive filed within 72 hours after death Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ı "natural", or items le itcal Examiner m 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2[**X**No 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 X No Specify: Maryland 21215-0036 <u>م</u> 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) Medical other than " Elementary/Secondary (0-12) College (1-4or 5+) Health Care Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item Z7 is marked ofth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) unk Marquess 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 109 Lockleven Drive Severna Park, MD 21146 Michael Lissau/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State timore, 20a. Method of Disposition August 08, 2008 1 X Burial 2 Cremation 3 Removal from State Meadowridge Memorial Park Elkridge, Maryland 4 Dopation 5 ☐ Other (Specify) 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 21. Inature Funeral Service ice see SAMES CO 495 Gov. Ritchie Hwy, Severna Park, MD 21146 FM1. En ir the disease, or in militations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or leart failure. List inly one cause on each line. Approximate Interval Between Onset and Death ediate use (Final ase o ondition sultin n death) Atherosclerotic Cardiovancular Discuse **Physician** /Medical Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Exami attending physician and for use as the burial-tran Atrial Fibrillation Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Year Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Completed by 1 Yes 2 No 3 Probably 4 Unknown Division or Vital Records. 2 should be 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Peripheral Vascular Diseuse autopsy perform page 2 No Price on any Discusse

25. Was case referred to medical examiner?

Hospital or Attending Physician: 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 08

State

31. Date filed (Month, Day, Year) AUG 0 7 2008

ANDREV GORDON MD 2003 Medical Privy 32. Refistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

		•	For State Registrar	State of M	aryland	/ Depa	artment of F rtificate of I	ieaith and i Death	Mental Hy	'giene Reg. No	7 11116	3 27133
-	Physicial		Decedent's Name (First, Middle,	Last)					2. Date of De	eath		3. Time of Death
4	Physici /Medic		Raymond		rwood		Inncont			st St	2, 2008	1339 <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution,					Location of Death	ח	40	County of Deat	
100	Funeral		WMHS-Memorial  5. Social Security Number  6	A	ge (In yrs. las	st birthdav)	Cumb	erland	8. Date of Bi	rth	Allega	any hplace (State or Foreign
8.	Director	3	232-62-7531		69	Yrs.	Months Days	Hours Min.	(Month, Di 07/24/	ay, Year	) Co	ountry)  Virginia
	pui w		Usual Residence of Decedent  10a. State 10b. County		I 100 City	Town or Lo	postion		017217		1,,,,	
	Maryla f shoved at	ō		Legany	Toc. City,		Cumberlan	d				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	r 28a-	rect	10e. Street and Number		<u> </u>		10f. Zip Code			10g. Ci	itizen of What Co	71
	th with	al D	555 Rose	Hill Avenu	е			21502			USA	
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	)	13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	D-	14. Race - Ame Black, White	
336	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🌠 Divorced	1 X Yes 2 ☐ If Yes, Give Year or Dates:	No Vietr	nam	1 ☐ Yes 2 🂢 No	Specify:		:	Specify:	Black
2-0	72 hou natura ilical E	ted	15. Decedent's (Specify only highest			16a. Dece	dent's Usual Occup	ation	tina	16b. k	Kind of Business/	
21215-0036	filed within 7 I Hygiene. other than "I ent, the Med	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of work done DO NOT use retired	during most or wor	Killy			
	filed v Hygie ther t	ပ္ပ	12 17. Father's Name ( <i>First, Middle, La</i>	2			Laborer	18. Mother's Nan	ne (First. Middle	. Maidei	Manufac	cturing
an	ild be Fental Ked o	To Be	Grafton	High	I	₋arger	nt	Hazel			inia	Spencer
Maryland	12 should be filed wan and Mental Hygiel is marked other thraumatic event, the		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Numl	per, City	or Town, State, 2	Zip Code)
	1 and 2 Health tem 27 i		Patricia L. Larg	gent / Ex-W			Rose Hi	ll Avenu	<u> </u>			
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3		cer	netery, cre	osition (Name of matory or other place		Date		ocation - City or	•
Itin	permit. Page Department of Important: If any Injury or once.		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li		Cum		nd Cremat	- 1	07/2008		mberland	L Home, P.A.
Ba	permi Depar Impor any Ir		Affile &	adams		1	404 Decat			-		21502
			23a. Pa T. F. ter the disease, or c shock, or heart failure. List or	omplications that caused aly one cause on each li	d the death. ine.	Do not en	er the mode of dyir	ig, such as cardiad	or respiratory	arrest,		Approximate Interval Between Onset and Death
à	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. <u>In</u> Due to (or as	tracer	rebra	Left He	morrhage				Onset and Dodg
	Examiner			Due to (or as	a conseque	erice or):						
	Po #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):						
	xecute and Il-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):			-			
68760,	ificate be executed g physician and as the burial-transit	calE		d		,						
		Aedical	VE EEU VE									
Вох	leath certifi attending for use as	ian/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal d	leath 3[	∃Ectopic pregnancy	,			23d. Date of del	livery Day Year
P.0.	The law requires that the death cert ate has been signed by the attending bage 2 should be detached for use a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	it time of dea	ath 5L	Other (specify) _			ľ	World	Day
	w requires that the d been signed by the should be detached	by Ph	Part II. Other significant condition	s contributing to death b	out not result	ing in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
or Vital Records,	equire sen siç ould b				_				1 🗆	Yes 2	2X No 3 Pr	robably 4 Unknown
Sec.	e law r has be	Completed							24a. Was	psy	24b. Were au	utopsy findings available completion of cause of
alF			05.11/							ormed? 2∭N	death? 1 ☐ Yes	2 □ No
Ž	Physician: r this certifica ral director, I	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:	ent 2∏FI	R/Outpatier	nt 3 DOA Oth	er:			a Flori (a	72.
10 0	ng Phy ter thi neral o		27. Manner of Death	28a. Date of Inju	ury 2	28b. Time o			28d. Describe		6 □Other (Spe ury occurred	iciny)
Sio	Attending r death. ector: After by the fune	catic	1 X Natural 5  Pending 2  Accident investiga 3 Suicide 6  Could no	the			M 1	Yes 2 □ No				
Division	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral dir	Certification:	4 Homicide determin	ad   28e. Place of inj	jury - At hom tc. <i>(Specify)</i>	ie, farm, str	eet, factory, office		28f. Location City or To	Street a wn, Stat	ind Number or Ri te)	ural Route Number,
	splta hours ineral y fillec		29a. Certifier 1 Certifying	Physician: To the best	of my knowl	ledge, deat	h occurred at the tir	me, date and place	and due to the	cause(s	s) and manner as	s stated.
	the Ho nin 24 the Fu	Medical		kaminer: On the basis of and manner st	ated.	on and/or in			urred at the time	, date ar	nd place, and due	e to the cause(s)
	To To	2	29b. Signature and title of certifier				29c. Licens	e number 4389			ate signed <i>(Mont</i> August	
	8+		30. Name and address of person w	no completed cause of a	leath (Item 9	Qa) (Tune		1,509			ususu .	, 2000
	MIS			gueroa, M.D	., 62	25 Kei	nt Avenue	, Cumber	land, M	D 2	1502	
State 31. Date filed (Month, Day, 1)  Registrar AUG 0 5 2				32. Registr	rar's Signatu	Local	1)					

DHMH 17 Rev 1/2001

State Registrar

nas

200 Glenn Street, Cumberland, MD

Stephen P. Crossland, M.D.,

31. Date filed (Month, Pay, Year) AUG 0 1 2008 32 egistrar's Signature

08-05702 **Donald Layton Matters** 

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008

	1- For State Certificate C	of Death	eg. No.
Physician/	Decedent's Name (First, Middle, Last)	2. Date of Dea Month	Day Year 0040 has
edical Examine	DOINED BETTON TELEFORM	July 25, 2	008 00401115
	Facility Name (if not institution, give street and number)     Howard County General Hospital	4b. City, Town, or Location of Death  Columbia	4c. County of Death Howard
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		rth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		rs. Months Days Hours Min. 02/11	/1945 Country PA
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	ation	10d. Inside City Limits
	PA BEDFORD EVERETT		1 Yes 2 X No
the Maryland a or 28a-f sh	10e. Street and Number		10g. Citizen of What Country?
3a or 3		15537	U.S.A.
r death with the Maryland or items 23a or 28a-f show must be notified at ouce.	11. Marital Status 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. Armed Forces?	/as Decedent of Hispanic Origin? (Specify Yes or N Yes, specify Cuban, Mexican, Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.
		Yes 2 X No specify:	Specify: WHITE
urs'aft itural" amine	or Dates:	ent's Usual Occupation (Give kind of work done	16b. Kind of Business/Industry
5-0036 ed within 72 hour lygiene. other than "natu he Medic 1 Exan	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use retired)  JCK DRIVER	PUBLICATION
5-0036 lled within 7 Hygiene. I other than the Medic	12 T.Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle,	
at Hyg	NONATO WITTIAM MATTERS	LUCILLE BURI	
MD 2121 d 2 should be fi th and Mental 1 n 27 is marked numatic event,	19a. Informant's Name/Relationship (Type, Print )	ing Address (Street and Number or Rural Route Nu	
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygies with a first and 17 is market other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once to a property of the Medical Examiner must be notified at once the first and the Medical Examiner must be notified at once the first and the Medical Examiner must be notified at once the first and the Medical Examiner must be notified at once the first and the Medical Examiner must be notified at once the first and the Medical Examiner must be notified at once the first and the Medical Examiner must be notified at once the first and the Medical Examiner must be notified at once the first and the Medical Examiner must be notified at once the first and the Medical Examiner must be notified at once the first and		6 MENCHTOWN ROAD, EVERE	TT, PA 15537
Baltimore, bernit. Pages I an Department of Hea Important: If iten njury or other tra	1 X Burial 2 Cremation 3 Removal from State crematory or	other place)	
timent trant:	4 Donation 5 Gitter Specify.	MORIAL CEM。 07/30/2008  Name and Address of Facility	B EVERETT, PA
Baltimo permit. Page Department o Important:	21. Signature of Funeral Scrice Locasee	DALLA VALLE FUNERAL SE 22 W. MAIN STREET, EVE	RVICE, INC.
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	r the mode of dying, such as cardiac or respiratory a	rrest, shock, or heart Approximate Interval Between Onset and
/Medical	failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic Cardiovascular D	isease	Death
Xammer	or condition resulting in death)  Due to (or as a consequence of):		
3	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
led Insit	(Disease or injury that initiated on the resulting in death). Last one of the resulting in death). Last one of the resulting in death). Last one of the resulting in death of the resulting in death of the resulting in death.		**
8 = = 1 .	UNPENDED AMENDED		=
		Fetal death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
Sox 687 death certifute attending d for use as t	4 Pregnant at time of death 5	Other (Specify)	INGINITY BUY
T ~ ~ T	1 Yes 2 No 9 Unknown g Unknown	Logo Bi	tobacco use contribute to the cause of death?
	Part II. Other significant conditions contributing to death but not resulting in the History of lung cancer	5 cm company of contract of co	res 2 No 3 ✓ Probably 4 Unknown
ds, I			is an 24b. Were autopsy findings available
2 a a 2		per	opsy prior to completion of cause of death?
		26.Place of Death (Check only one)	3 2 ✓ No 1 Yes 2 No
/ita	examiner?	I Othor	Residence 6 Other:
of \officers	27 Manney of Dooth 290 Date of Injury 29h Time		e how injury occurred
ion ttendi death. ttor: //	1 V Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 4 Homicide Could Natural 6 Specify)	treet, factory, office building, etc. 28t. Location or Town	(Street and Number or Rural Route Number, City , State)
Divineral I	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death or	curred at the time, date and place, and due to the ca	ause(s) and manner as stated.
To the How within 24 h To the Fur	22 2. Certifying Physician: To the best of my knowledge, death of one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated.	gation, in my opinion, death occurred at the time, da	te and place, and due to the cause(s)
To with	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
25	forh Jegmo	O.C.M.E.	July 26, 2008
SM 0 A	30. Name and address of person who completed cause of death (Item 23a)  Tasha Greenberg MD. Assistant Medical Examiner 1	11 Penn Street, Baltimore, MD 21201	
nds			
Sta Registr		ale	

08-05596 Ronald Offer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 27136

				Certificate	of L	Death				g. No.		00 277
	Physicia Examir	ın/	Registrar  1. Decedent's Name (First, Middle, Last)  Ronnol S. Offer Ronnell	Steadwid					Date of Dear Month July 22, 2	Day Ye		3. Time of Death 0254 hrs
			Facility Name (if not institution, give street and number)     I-83 North, 1 Mile South of Belfast Road		4b	. City, Town, or Lo Sparks				4c. County Baltimo	re Cou	unty
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In	n yrs. last birthday)		If Under 1 Year Months Days	If Under Hours	24Hrs. Min.			I - oreid	thplace (State or gn puntry) Maryland
	hiector		213-21-8729 1 1 1 2 F Usual Residence of Decedent 10a. State 10b. County 10c	2.5 c. City, Town or Lo	Yrs.	on .			reb_3	1983		10d. Inside City Limits 1 Yes 2 No
	*	ŽĮ	Maryland Anne Arundel	Gales	vi			21		I0g. Citizen of V	(hot Co)	
	Aaryla 28a-f 1 at o	Direct	10e. Street and Number			10f. Zip Code				rog. Citizen or v	mat God	anu y :
	ith the Maryland 23a or 28a-f sho notified at once.		937 W. Benning Rd.	110 112	10/00	2076 Decedent of Hispa		in? ( Spe	cify Yes or N	US 0- 14. Rad		rican Indian, Black,
	A 19-0030  be filed within 72 hours after death with the Maryland mial Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Event 12. Was Decedent Event 13. Never Married 2 Married Armed Forces?		If Ye	es, specify Cuban, I	Mexican,	Puerto F	tican, etc.)	Wh	ite, etc.	
	ter dea		1 Yes 2X	No 1		Yes 2X No	specify:					ack
	ZIZIO-0030 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner.	d by	or Dates.	eted) 16a. Dece	edent	's Usual Occupationst of working life. I	on (Give k	ind of wo	ork done ed)	16b. Kind of I		
	72 ho	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	35								States
200	within iene.	Jmp	12th 0			Stocker	8.Mother	s Name	First, Middle,	Maiden Surnar		change
4 5	filed Il Hyg ed oth t, the	BeC	17. Father's Name (First, Middle, Last)  Ronnie Offer				Sons	za N	orel =	ha		
2,0	e a se e	B	19a. Informant's Name/Relationship (Type, Print )			Address (Street	and Num	ber or R	ural Route Nu	mber, City or To		
	S of D is is	-	Pauline Proctor(Grandmot					g. Ro	. Gal	esvill	e,	Md. 20765 or Town, State
	and leal leal tra		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State	crematory	or oth							
	Pages ment of tant: If or other		4 Donation 5 Other Specify:	ppenez								.11e, Md.
3	Baltimore, permit Pages I a Department of He Important: If it injury or other t		21. Signature of Funeral Service Licensee			lame Receive				_		
מ			23a. Part I. Enter the disease, or complications that caused the	ne death. Do not er	8 Z	1 West	St.	Anr ardiac o	respiratory a	s, Ma.	heart	Approximate Interval
	hysician! ledical!		failure. List only one cause on each line.	le death. Do not of								Between Onset and Death
	xaminerــٰـx		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a conseq	uence of):	_			-				
			Sequentially list conditions, b.									
		ner	if any, leading to immediate  Cause Enter Underlying Cause  Due to (or as a consequence)	juence of):								= 1
	_	Examiner	(Disease or injury that initiated events resulting in death) Last	juence of):								
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	760, cate be execut physician and he burial - tra	Medical	X AMENDED $#1$ ,		02	0/22/00	11			23d. Dat	e of deliv	Wen/
	_ = ==			2		etal death 3	Ectop	ic pregna	ancy	Mont		Day Year
	Box 687 death certification attending	Physician	1 Yes 2 No 9 Unknown 9 Unknown	5		ittler (Specify)						
	D.O. By that the de ned by the detached i	占		but not resulting it	n the	underlying cause of	given in F	Part I.				e to the cause of death?  Probably 4 Unknown
	ords, P.O. w requires that the seen signed by should be detach		<u> </u>									e autopsy findings available
	rds requi	de	<u></u>							topsy	prior death	to completion of cause of
	ecol ne law te has	۱۱ و								erformed? es 2 No		Yes 2 No
	of Vital Records, ag Physician: The law requir of the this certificate has been super director, nage 2 should?	2				26.Place			only one)			
	Vita nysicis this ce	9	1 Yes 2 No				Other <sub>4</sub>		ng Home 5	Residence		other: Scene
	on of Vital Rec inding Physician: The urh. r: After this certificate he fineral director, page	i dilicia		ry 28b. Tir FOUN 0245 I	1D:	" /	ury at Wo	-	Pedestria	an struck by	auto	
	Division Hospital or Attendit 24 hours after death. Funeral Director:  Attendity filled in by the fil	to III no	2 Accident  Could not be determined (Specify) Inter-		m, str	eet, factory, office	building,	etc.	28f. Location or Tow 183 North	on (Street and N n, State) 1 Mile South	umber o	or Rural Route Number, Cit ast Road, Sparks, MD
	Di ne Hospital n 24 hours : ne Funeral			knowledge deat	h occ	urred at the time, o	date and pon, death	place, ar occurred	d due to the a	cause(s) and madate and place,	anner as and due	stated. to the cause(s)
	To the within To the	СОШ	(Check only 2 Medical Examiner: On the basis of examiner on the basis of examiner and manner stated.  29b. Signature and title of certifier			29c. Licen						(Month, Day, Year)
			(X anterleans)			0.0	.M.E.			July 22	, 2008	3
			10. Name and address of person who completed cause of de Laron Locke MD. Assistant Medical Exa	aminer 111	Per	nn Street, Balt	imore,	MD 21	201			
		Sta	ALIC A R 2008 HO	r's Signature	4	Level i						
	Reg		7,00	ORI	GIN	ΙΔΙ						
DI	HMH 17 Rev	1/200	J1	UKI	יווטי							

**Physician** /Medical Examiner **Funeral** Director show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, I'm Medical Evaminer must be notified at once. Baltimore, Maryland 21215-0036

Funeral Completed Be ပ **Physician** /Medical Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran Box 68760. Physician/Medical signed by the a P.0. Division of Vital Records, cate has been signated by page 2 should b Completed certificate director, Be Certification: To this After this funeral d To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral Medical 4/17 State Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Poe Month August +re 5,2008 Facility Name (If not institution, give street 4b. City, Town, or Location of Death 4c. County of Death Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 213-42-3178 Months Hours Virginia Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2XXNo Director North East Maryland Ceci1 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21901 30 Belvue Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 1966–6 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 1966-68 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hote1/Restaurant Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gurnie W. Poe Bessie Pearl Rogers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 917 North Bridge Street, Elkton, Maryland 21921 Sandra Poe / Daughter 20b. Place of Disposition (Name of cometer, crematory or other place)
NOTER LASE Methodist
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from Sta August 8, North East, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Crouch Funeral Home 27 South Main Street, North East, Maryland 21901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final -years disease or condition resulting in death) Due to (or as a consequence of): 0 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Year Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. non combi 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an autopsy perform 2 No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) Hera Sempos, M.D., VAMaryland Nearth Care System, Perry Point, MD 21902
31. Date filed (Month, Day, Year) 32. Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 4, 12:44 AM Piatt 2008 Nancy Lee August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WMHS-Memorial Campus Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months Hours 1 □ M 2 🛣 F 63 Yrs. West Virginia 04/11/1945 Director 212-44-3124 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hygiene.

marked other than "natural" - 1 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 X Yes 2 □ No MD Cumberland Allegany Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21502 318 Fayette Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: Completed by 3 ☐ Widowed 4 🕅 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Shoe Repair 8 Co-Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be 1
Department of Health and Mental I
Important: If item 27 is marked of
any injury or other traumatic eve Piatt Mildred Helen Mallory Sullivan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 276 Bond Street, Cumberland, MD 21502 Nancy P. Plummer/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State Cumberland Crematory 08/07/2008 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. \$ignature of Funeral Service Licer 22. Name and Address of Facility Adams Family Funeral Rome, I.A. 404 Decatur Street, Cumberland, MD 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 24 Hours Ventricular Arrhythmia /Medical Due to (or as a consequence of) Examiner Carcinoma Colon Sequentially list conditions, it any, loading to immodule cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Ovarian Mass sician and burial-tran Due to (or as a consequence of): physician a the burial Physician/Medical attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 📉 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hypertension 24a. Was an performed' certificate 1∐ Yes 2∭ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.
he Funeral Director: A
pletely filled in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Box 68760. Records, P.O. **Division or Vital** Hospital or Attending Physician:

Maryland 21215-0036

Baltimore,

nls

To the within 2.

State Registrar 29b. Signature and little of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Noshin Qaisrani, M.D., 3 Registrar's Signature 31. Date filed (Month, Day, Year) AUG 0 5 2008

and manner stated.

, lais raw

500 Memorial Avenue, Cumberland, MD

29c. License number

D0064167

29d. Date signed (Month, Day, Year)

August 4, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 8 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 02 2008 August 0128 James Arthur Runser 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Carrol1 Carroll Hospice Dove House Westminster 8. Date of Birth (Month, Day, Year) Year If Under 24 Hrs Davs Hours Min. Birthplace (State or Foreign Country) Social Security Number Months **№** M 2 🗆 F 186-22-9295 Oct 12 1930 PA 10c. City, Town or Location 10d. Inside City Limits 10h County 1 ☐ Yes 2 No Westminster Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21157 USA 612 Woodside Drive 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 Married 1952 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 1955 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Allied Signal College (1-4or 5+) Elementary/Secondary (0-12) Technical Services Human Resources Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mabel Glancy Raymond Runser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 612 Woodside Drive Westminster, MD 21157 Patricia Runser/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 08/05/2008 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Carroll Cremation, Inc 4 □ Donation 5 □ Other (Specify) Hampstead, MD Printend Pointer and Chapel, P.A. 21. Signature of Funeral Service 412 Washington Road Westminster, MD 21157 Approximate Interval Between Onset and Death , or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Parti. Enter the disease, or con shock, or heart failure. List only Mobintate Immediate Cause (Final Concor MONTING

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

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ral", or items 23a or 2

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7 is marked other traumatic event, the

Department of Health an Important: If Item 27 is any injury or other trauonce.

Director

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Pages 1 and 2 should be filed within 72 hours after death 'nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

physician and stran tran

Hospital or Attending Physician: The law requires that the death certificate be executed

To the

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IOTIVA

Division or Vital Records, P.O. Box 68760,

Medical Certificatio within 24 hours after death

To the Funeral Director;
completely filled in by the

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

6 ☐ Could not be

AUG 0 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29

	resulting in death)	a		- 1		ZPICIAN)					
		Due to (or as a consequ	ience of):								
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b Due to (or as a consequ									
	that initiated events resulting in death) Last	Due to (or as a consequent	ience of):								
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ □ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 ☐ Ectopic	pregnancy specify)		23d. Date of delivery Month Day Year					
	Part II. Other significant conditions	contributing to death but not res	ulting in the underlying	cause given in Part I.		use contribute to the cause of death?  ☐ No 3 ☐ Probably 4 ☐ Onknown					
Completed					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2  1					
Be (	25. Was case referred to medical	26. Place of Death (Check only one)									
To B	examiner? 1 Yes 2 No	Hospital: 1   Inpatient 2	ER/Outpatient 3 1	OOA Other: 4 Nursing H	ome 5 Residence	6 Nother (Specify) Hospice					
tion:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ry occurred					

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

HUC

29d. Date signed (Month, Day, Year)

2808

Registrar DHMH 17 Rev 1/2001

State

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Stone

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Elizabeth S. Reese August 06 2008 4:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lorien of Taneytown Taneytown Carroll If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2X F Nov 22 1919 Director 215-18-1622 88 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 3a or 28a-f show t be notified at 1 XYes 2 No Director MD Westminster Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a 108 East Green Street 21157 USA items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status the Medical Examiner Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: þ 3 XWidowed 4 ☐ Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cafeteria Manager Board of Education 7 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Shaeffer Mary Tressler 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Thomas J. Reese/son 2145 Herbert Avenue Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ∃08/06¶2008 permit. Pages Department of Important: If II any Injury or c 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Carroll Cremation, Inc. Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Pritts Funerally Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical a consequence of) Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a conseque The law requires that the death certificate be executed anding physician and use as the burial-transit Exami Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal de 23d. Date of delivery 23b. Was decedent pregnant aften for u 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si should i 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has b lirector, page 2 s 24a. Was an 1□ Yes 2 NO To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

JI

State Registrar 31. Date filed (Month, Day, Year)

AUG 0 6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Street, Manchester, MD 21102

			1 - For State Registrar	State of M	<b>1ar</b> ylar			nt of H				giene	200	18	27	141
	Physic /Medi		1. Decedent's Name (First, Middle, L. Elizabeth Runyo	,							2. Date of De Month August	Day	2008	ear	3. Time of 4:16	
1	Examir		4a. Facility Name (If not institution, gi Charles County N			ab	4b. Cit	y, Town, or LaPla		of Death		4c.	County of			
	Funeral Director		232-34-3606	Sex 7. A 1 □ M 2 □ F	ge (In yrs. 81	last birthday) Yrs.	If Und Month	er 1 Year Days	If Under Hours	Min.	8. Date of Bin (Month, Da ember	y. Year)		9. Birthp Cour	olace (State htry)	or Foreign
	death with the Maryland ims 23s or 28s-1 show	Director	Usual Residence of Decedent  10a. State 10b. County  MD Charle	es		ty, Town or Lo								1	0d. Inside C	City Limits
	th with the	ai Dire	10e. Street and Number 9683 Charles Str	eet			10f. 2	ip Code 2	0646			10g. Citi:	en of Wh		ntry?	
036	ours after of, or its Examine	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1  Yes 2 If Yes, Give Year or Dates	? ] No		Was Dec If Yes, sp	edent of H ecify Cuba			cify Yes or No Rican, etc.)		4. Race -	Americ White,	en Indian, etc. Vhite	
21215-0036	within 72 hours ane, then "naturel", ne Wedical Ex-	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or	5+)	life.	kind of v DO NOT	vork done d use retired	during mos	st of workin	g	16b. Ki	nd of Busi		ŕ	
Maryland 2	2 should be filed withir and Mental Hygiene, is marked other then aumatic event, the Ma	To Be Co	17. Father's Name (First, Middle, Las Ray V. Willson			1 103	ache	<u>r</u>			(First, Middle, [aylor	Maiden		cati	lon	
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 ha popartment of Health and Mental Hyglene. Important: if item 27 is marked other than "natur eny injury or other traumatic event, the Medical QDCs.		Pan Informant's Name/Relationship Randall Runyon/S  20a. Method of Disposition  1 Burial 2 □ Cremation 3 [ 4 □ Donation 5 □ Other (Speci	O∏ □Removal from State	20b. F	P.O. Place of Disponentery, cremetery.	Box esition (N matory of Memor	114, ame of other place	La F Gar.	lata. 8/16/	MD 20 ate 2008  ERAL HO	646 20c. Lo	cation - Ci	it <b>y</b> or To		nd
8760,	Physician /Medical /Medical Examiner	Ilcal Examiner	23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pail v	s a consequence of a co	to 7ho quence of): ementi quence of):	Ive								Intervat Be Onset and Mint	Death
P.O. Box 6	The law requires that the death certific tie hes been signed by the ettending p. page 2 should be detached for use as I	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 In No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	Il death 3	Ectopic Other (	pregnancy specify)				2	3d. Date Month		ory Day	Year
rds, r	quires inat n signed b ud be deta	ed by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did to							tobacco use contribute to the cause of death?  Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknow						
Heco		Completed by	Congestive he	art fail	U/-						24a. Was autor perio 1 🗆 Yes		pride	or to coa	psy findings mpletion of	
t Vita	Physicien: rthis certifice ral director, I	To Be (	25. Was case referred to medical examiner?  1 Tyes 2 No	Hospital: 1 ☐ Inpat	ient 2 🗆	ER/Outpatien	nt 3 🗆 🖸	Othe Othe	10		(Check only one 5 ☐ Resid	пе)				
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	To the Hospital or A within 24 hours effer To the Funerel Directory completely filled in by	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	nysician: To the bes miner: On the basis and manner s	or examina	owledge, death ation and/or in-	n occurre vestigatio	d at the time	ne, date ar pinion, dea	nd place, a ath occurre	nd due to the d at the time,	cause(s) date and	and manr place, an	ner as si	tated. the cause(	(s)
)	To the To the Comp	Me	29b. Signature and title of certifier	- M	?		2:	9c. License		_			signed (		Day, Year)	
2	B20		7	FARE ,	M	12070		Line	Cent	re, S	Suite 1	O,Wa	ldor	f,MI	2060	)1
	Sta Registr	-	31. Date filed (Month, Day, Year)  AUG 0 8	2008 32. Pigist	trar's Signa	ature /										

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland			t of Health e <i>of Deatl</i>				008	27142
			Registrar  1. Decedent's Name (First, Middle, Last	······································					2. Date of Dea	th		3. Time of Death
	Physicia		ALICIA R	IVERA					Month OS	Day	Year 200 %	2343 M
	/Medic Examin		4a. Facility Name (If not institution, give	4b. City,	Town, or Location	n of Death		_	nty of Death			
	⊏xamın		Washington Adventi			Takor	na Park			Mont	gomery	<b>y</b>
_	Funeral		5 Social Security Number 6 Se	7 Age (In vrs. las	t birthday)	If Under Months		er 24 Hrs. Min.	8. Date of Birtl (Month, Day	(Year)	Cour	place (State or Foreign
	Director		581-03-8620	Эм 2Ы 87	Yrs.	MOUNTS	Days	1	Apr. 1,	1921	Puer	tő Rico
	p		Usual Residence of Decedent	100 034	Farra ar I ar	ntion						0d. Inside City Limits
	show	_	10a. State 10b. County		Town or Loc	Jation						1⊠Yes 2 □ No
	8a-f	Scto	MD Prince Ge	orge's Adelp	ohi	10f. Zip	Code			10a Citizen	of What Cour	ntry?
	vith th	ä	10e. Street and Number	201.0		207				SA		,
	be filed within 72 hours after death with the Maryland ntal Hygiene. 3d other than "natural", or items 23a or 28a-f show event, the Medical Examirar must be rediffed at	Funeral Director	9200 Edwards Way #	12. Was Decedent Ever in U.S.	13 \	1 _		Origin? (Spe			Race - Americ	can Indian,
	item	Š	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed Forces?  1 \( \text{Yes} \) 2 \( \text{XNo} \)	10.1	f Yes, spec	lent of Hispanic ( cify Cuban, Mexic		Rican, etc.)		Black, White,	etc.
99	Ir, or	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	I∭ Yes ∶	2 ☐ No Speci	<sup>ify:</sup> Puer	to Rica	n Spe	ecify: His	panic
ğ	2 hou	ted	15. Decedent's Ed		16a. Deced	lent's Usua	al Occupation	ant of working	20		f Business/In	
7	in 72	ble	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)			rk done during m se retired)	OSLOI WOLKII				
2	d with giene er tha	Completed		4`I	Regist	<u>tered</u>	Nurse			Healt		
힏	e file al Hy I othe vent	Be (	17. Father's Name (First, Middle, Last)				- 1		(First, Middle,	Maiden Suri	name)	
<u>a</u>	2 should be filed w and Mental Hygie is marked other t aumatic event, In	၉	Federico Ramos Ant	onini				isa Yo				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		19a. Informant's Name/Relationship (TISMael Rivera/hush		19b. Mailin 9200 I	ng Address Edwar	(Street and Num	nber or Rura 1-313 A	delphi.	er, City or To MD 2	wn, State, Zij 0783	o Code)
	1 and 2 Health tem 27 i		20a. Method of Disposition						ate		on - City or To	own, State
Ö	Pages nent of f ant: If ite ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	ce of Disponetery, cren	natory or o	ther place) matory	08/11	/08	Relts	ville,	MD
Baltimore,	it. Partmen	н	4 Donation 5 Other (Specify	0.1								
Ba	permit. Departr Importa any Inju		21. Signature of Funeral Service Licen	elette MO12	G(	oing	Home Cre	ematic	n Servi	ce r	.U. BO kevill	x 704 e, MD 21029
		-	23a. Part 1. Enter the mease, or comp	olications that caused the death.	Do not ent	er the mod	le of dying, such	as cardiac	or respiratory a	rrest,	COALL	Approximate Interval Between
	Diam'r in in a		shock, or heart failure. List only immediate Cause (Final	one cause on each line.		Λ1	.1.					Onset and Death
N. W.	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a cons g e		une	eu					
1	Examiner			Aute lu	AD ( )	rdia	1 Inter	Hear	,			
	_ 6.00	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nre of):		7					
	oute id ansit	Examiner	Cause (Disease or injury that initiated events	C	e		1931					
ó	an ar		resulting in death) Last	Due to (or as a conseque	nce of):							
8760,	icate be executer physician and the burial-transit	dical		d								
9	ing ph	Med	IF FEMALE:									
Вох	eath certific attending p	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnan 1 Live birth 2 Fetal of	leath 3	Ectopic				23d	. Date of delive Month	very Day Year
0	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	ath 5L	Other (s	pecify)					
σ.	that the de ned by the a detached t	Phy	Part II. Other significant conditions of	ontributing to death but not result	ing in the u	nderivina	ause given in Pa	art I.	23e. Did 1	obacco use	contribute to	the cause of death?
g,	signe signe	by	Demanta		Ü	, ,			1 🗆	Yes 2□1	lo 3∏ Pro	bably 4 Minknown
Ö	v requir been s should	Completed	2200000						24a. Was	an 2	24h Were auf	lopsy findings available
ž	: The law cate has page 2 s	ם							auto		prior to c death?	ompletion of cause of
a	ilcian: Th certificate rector, pag					<u>.</u>				212 No	1 □Yes	2 □No
Ξ	Physician: this certific al director, I	Be	25. Was case referred to medical examiner?	Hospital:	7.0		Othor		h <i>(Check only o</i> ome 5 ☐ Res		Other (Case	S.E.A.
of	Phys ratidis	lç.	1 Yes 2 No 27. Manger of Death	28a. Date of Injury	28b. Time o		28c. Injury at	J Nursing Ho	28d. Describe			y)
on	ding h. Afte fune	ţi	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	М	Work? 1 ☐ Yes 2	2 □ No				
Division of Vital Records,	Attending Physician: r death. sctor: After this certific by the funeral director, I	fica	3 ☐ Suicide 6 ☐ Could not b	28e. Place of injury - At nor	ne, farm, st	reet, factor	y, office		28f. Location (	Street and N	lumber or Ru	ral Route Number,
Ö	i de	Certification: To	4 ☐ Homicide determined	building, etc. (Specify,	1			-	City of 10	wri, Otate)		
	To the Hospital or Attending Phy within 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral		29a. Certifier 1 ☐ Certifying Pl	nysician: To the best of my know miner: On the basis of examinati	rledge, dea on and/or i	th occurred	d at the time, dat n, in my opinion,	e and place death occur	, and due to the rred at the time	e cause(s) ar , date and pl	nd manner as ace, and due	stated. to the cause(s)
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	with Cor	2	29b. Signature and title of certifier  Saluyasach	User, MO		28	D0063	Je3			1040	
			2				T.GOLD T	CARD	oll h	5 O 11.7€305/05	16	0
1	240		30. Name and address of person who	completed cause of death (Item	23a) (Type,	, Print)	TAKON	IN PA	RK, N	D		
7	1000		31. Date filed (Month, Day, Year)	32. Refistrar's Signati	ıre				/			
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			1 - For State	State of IVI	arylani		rtificate of	lealth and N Death		Reg. Na C	008	27143
			Registrar  1. Decedent's Name (First, Middle, L.	not)			incate of	Death	2. Date of Dea		00	3. Time of Death
	Physici	an	1. Decedent's Name (First, Middle, L.	151)					Month Day Year			
	/Medic		GENEVIEVE ROS				4h Cihi Town o	or Location of Death	08	01 4c Cou	2008 inty of Death	8:20A M
	Examin	er	4a. Facility Name (If not institution, gi				CUMBERI				EGANY	
			ALLEGANY COUNTY  5. Social Security Number 6.			ast birthday)	If Under 1 Year		8. Date of Birt	th	9. Birth	nplace (State or Foreign
	Funeral Director			1 □ M 2X□ F	90	Yrs.	Months Days	Hours Min.	3-14-1	y, Year)	Coi	PA
			Usual Residence of Decedent						1 7 1 4 1			
	yland		10a. State 10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Limits
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	n the	ire	10e. Street and Number				10f. Zip Code			10g. Citizen		untry?
	within 72 hours after death with the Maryland ene. Than "hetural", or Items 23e or 28e-f show ha Madical Ezanether inuat be molified at	Funeral Director	112 Schellsburg	St. PO Box	372		155				SA	
	ems dea	iner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Decedent of h If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. F	Race - Amer Black, White	rican Indian, e, etc.
92	or it	by Fu	1 ☐ Never Married 2 ☐ Married	1 ∐Yes 2 ∰ If Yes, Give	No		1□Yes 2\\X\\	Specify:		Spe	city: W	nite
Ö	urai'	d b	3 XWidowed 4 □ Divorced	Year or Dates:		16a Daga	dent's Usual Occup	nation		16b. Kind <i>a</i>		
5	net	lete	15. Decedent's 1 (Specify only highest g	rade completed)		(Give	kind of work done  DO NOT use retire	during most of work d)	king	TOD. TUITO	1 540,110041	
21215-0036	filed withi Hygiene. other than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		hboard O			Banl	king	
N	Hygi Hygi ther	Š	17. Father's Name (First, Middle, Las	t)			•	18. Mother's Nam	e (First, Middle,	Maiden Sun	name)	
Maryland	d be entai	To Be	Benjamin Earl En	erick				Mabel 1	M. Poorl	baugh		
₹	2 should be filed within and Mental Hygiene. Is marked other than " aumatic event, the Mac	F	19a. Informant's Name/Relationship			19b. Maili	ng Address (Street	and Number or Rui	ral Route Numbe	er, City or To	wn, State, 2	Zip Code)
Σ	and 2:		Charlotte M. Sha	ffer/ Daug	hter	112	Schellsb	urg St. P	0 Box 3	72 Hyn	dman I	PA 15545
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Insportant: If item 27 is marked other than "netural; or items 23e or 28e-f show any injury or other traumatic event, the Madical Examination must be notified at once.		20a. Method of Disposition	, ,	20b. P	lace of Dispo	osition (Name of matory or other pla		Date			Town, State
ē	ages ant of t: If i		1 ☑ Burial 2 ☐ Cremation 3  '4 ☐ Donation 5 ☐ Other (Spec			•	Cemetery	1	-2008	Hvndi	man, I	PA
Baltimore,	artme ortar injur		21. Signature of Funeral Service Lic		, <u>11</u> y			ess of Facility Ha				
m	Departiment of the service of the se		1111 Max	11/1 THA	7/			169 Clare		NIII AND		
			23a. Part1. Enter the disease or co shock or heart failure. List on	nplications that cause	d the death	n. Do not en	ter the mode of dy	ng, such as cardiac	or respiratory a	rrest,	568-56-3	Approximate Interval Between
	Physician		Immediate Cause (Final	y one cause on each	irie.	. 0	lane 1	hierre.				Onset and Death
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89	death certificate I e attending physi of for use as the b	Physiclan/Medic	IF FEMALE:									
Вох	th ce tendi r use	an/I	23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			□Ectopic pregnanc	су		23d.	Date of deli Month	livery Day Year
	e dea he at hed fo	sic	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant a 9□Unknown	it time of d	eath 5	Other (specify) _	·				,
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Division of Vital Records,	2 5 8	nple							24a. Was	nev	4b. Were au prior to death?	topsy findings available completion of cause of
Œ	T age	Completed							1 ☐ Yes	ormed?	1 Yes	2 □ No
/ita	Physician: The rath certificate ral director, page	Be	25. Was case referred to medical examiner?	Manitali			0.	26. Place of Dea				
$\leq$	S 5	2	1 ☐ Yes 2 ☐ No	THE PARTY NAMED IN COLUMN			nt 3 DOA		ome 5 Resi			cify)
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Sio	Attending r death. sctor: After by the fune	Certification;	2 Accident investigat 3 Suicide 6 Could not	h	diame. At hi	ama farm at	M 1 [	Yes 2 □ No	28f Location /	Street and N	umber or R	ural Route Number,
₹	or At fler of Direction by	E	4 Homicide determine	d 289. Place of it	tc. (Specif	y)	ireet, ractory, onice		City or To	wn, State)	3/100/ 0/ /10	
	To the Hospitei or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	2	29a. Certifier X Certifying	Physician: To the bes	t of my kno	wiedos des	th occurred at the t	me date and place	and due to the	causa(s) and	d manner a	s stated.
	Hos 24 ho Fun fely i	edical		aminer: On the basis and manner s	of examina							
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	una mannet s	.2.00.		29c. Licen	ise number		29d. Date si	gned (Mont	th, Day, Year)
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	8		30. Name and address of person w	o completed cause of	death /Iter	n 23a) /Tuna	Print)	7700		Ty		
	nKS		Sunil K. (-UP	o completed cause of	.75	Kent	Ave. Suit	e 101 Co	mberle	and n	10 2	1502
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DHMH 17 Rev 1/2001

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State of Maryland	Department of Health	and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Rafferty August 3, 2008 Angela Felicia 12:05 AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Allegany Golden Living Cumberland Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 💢 F 88 Yrs. 214-14-5156 Director 12/06/1919 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 X Yes 2 □ No Cumberland MD Allegany Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 USA 235 Paca Street Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 217 No Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping State Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Bonomo Carmella Papalardo ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 723 Bedford Street, Cumberland, MD Cecilia Aman / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State St. Mary's Cemetery 08/06/2008 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign sure of Funeral Service I 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) U years **Physician** 60 ronge /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician; The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ▼ No 9 ☐ Unknown the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Tyes director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury. At home, farm, street, factory, office building, etc. (\$pecify) 4 ☐ Homicide To the Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 4, 2008 D36766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 924 Seton Drive, Cumberland, MD Vik Poonai, M.D., 31. Date filed (Month, Day, Year) 2. Registrar's Signature State AUG 0 5 2008 Registrar

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Edgar, Stickell **Physician** 5:22°M 08 17 Dernard 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Medical Center ltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number **Funeral** Jex 1 M 2 □ F Days Months Hours MARYLAND 10-13-47 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral Race - American Indian Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 Married 1 Never Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify DhITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be KARNARD E. STIC 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) THELMAR. STEKEL DODHOLM CIR. PASADENA, MD. Z1122 20c. Location - City or Town, State Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐Removal from State 8-19-08 4 ☐ Donation 5 ☐ Other (Specify) HANOVER MO. 21. Signatur f Funeral 22. Name and Address of Facility Daugher & Fanily FUNERAL HOME 2601 MOUNTAIN AD. PASADENY, MD. Z1122 Approximate Interval Between Onset and Death Part1. Enter the disease, a complications that cau shock, or heart failure. List only one cause on oac not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Sepsis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed sician and burial-trans P.O. Box 68760,0 Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) signed by the at d be detached for 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed Congestive Heart Failure 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒No 24a, Was an autopsy 2 No 1☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA မှ funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After to ompletely filled in by the funeral 5 □ Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Fo the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 22

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2008

MD

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32. Registrar's Signature

DHMH 17 Rev 1/2001

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N. Greene Street Baltimore MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 255, 221, 28 Mary per menages 200 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** 16, 2008 July Hannah L. Starks /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georrges Fort Washington Fort Washington Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🔀 F 579-22-7410 92 June 4,1916 Director VA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. Counfy 'natural", or items 23a or 28a-f show dical Examiner must be notified at 1 T¥Yes 2 □ No Director Temple Hills PG Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20748 Place 4308 Beaman Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2₹ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 Tyes 2 No. Specify: Specify. þ Black 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic event, the N Custodian Government 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ith and Mental h Be William Younger Gracie Pearl Trainer ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 4308 Beaman Place
Temple Hills, Md.

20b. Place of Disposition (Name of cemetery, crematory or other place) John Starks Jr./son 20748 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Suitland, Md. Lincoln Mem. Cem. 7/19/08 4 □ Donation 5 □ Other (Specify) 21. Signal re of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part Enter the disease, or complications that od sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shody, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) teule My ocard Physician APPROVEUS MEDICAL EXAMINER /Medical Due to (or as a consequence of): Examiner + va sit any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): CERTIFICATION Examine D sician and burial-trans Due to (or as a consequence of): physician a the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1 Yes 2 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Impatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of **pm** 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? After 1 5 Pending investigation Subject fell. 1 Accident 07/07/2008 Unknown 1 ☐ Yes 2 TNo 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Home 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4308 Beaman 3 ☐ Suicide determined 4 Homicide Place, Temple Hills, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: completely filled in by the the

Division or Vital Hecords, P.O. Box 68760,

with

death v

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

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State Registrar

29c. License number 46046 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mirza Alikhani 11711 L ed (Month, Day, Year) 2. Registrar's Signature Livingston Rd., Fort Washington, Md. 20744 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0ay 04 2008 11:00 am August Robert Francis Steeble /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Reisterstown 122 Sacred Heart Lane 8. Date of Birth (Month, Day, Feb 20 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Days 1920 Hours Months M 2□ F PA 88 201-03-8650 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a, State ortant; if item 27 is marked other than "natural", or items 23a or 28a-f sho. Injury or other traumatic event, the Madical Examiner must be notified at 1 ☐Yes 2 No Director Reisterstown MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21136 USA 122 Sacred Heart Lane death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No WWII If Ves, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 ZNo Specify: Specify: White ð 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: if item 27 is marked other than any Injury or other traumeth. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Senior Claims Investigator John Hancock Ins 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eva Stockley William John Steeble 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2888 Uniontown Road Westminster, MD Natalie Nicholson/daughter Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 08/08<sup>D</sup>/2008 ¥☐ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Bartholomew Church Cem 4 ☐ Donation 5 ☐ Other (Specify) Manchester, MD 21. Signature Funer Prints funeral Home and Chapel, P.A. Cul 412 Washington Road Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Days **Physician** disease or condition resulting in death) /Medical Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 □Yes 2 □No Year Month Day 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. 2 2 2100 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? this certificate ! 2 X No 1 ☐ Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To completely filled in by the funeral 28d. Describe how injury occurred 28b. Time of 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Division Injury 1 Natural 2 Accident 5 Pending investigation ne Hospital or Attendir n 24 hours after death. Ne Funeral Director: A 1 ☐ Yes 2 ☐ No 3 □ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Terrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 151 6+1 VA Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

# Amended Item 2 per Phy. 08/06/2008 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	_ State	State of Maryland / D	Department <i>Certificate</i>			ental Hygi	ene g. N2 0	801	27148
			Registrar  1. Decedent's Name (First, Middle, Last)					2. DatA of Beat			3. Time of Death
	Physicia			Connor				Vuguet 0			11:30 A. M
	_/Medic		Dolores Margaret  4a. Facility Name (If not institution, give str		4b. City, 7	Town, or	Location of Death	Lague C		nty of Death	
	Examin	er	St. Vincent Care		Fmm	itch	urg,		Fr	ederi	ck
			5. Social Security Number 6. Sex	7. Age (In yrs. last bir	thday) If Under	1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birth	place (State or Foreign intry)
	Funeral Director		1 🗆 1	<sup>1 2</sup> √ F 74		Days	Hours Min.	Dec. 18	<b>,</b> 1933	3 Ma	ryland
			213-30-3550 Usual Residence of Decedent	/4							
3	and ow		10a. State 10b. County	10c. City, Tow	n or Location						10d. Inside City Limits
	Mary	to	MD Frederic	k Emmi	tsburg						1.X. Yes 2 □ No
	28a	Director	10e. Street and Number		10f. Zip	Code		10	0g. Citizen	of What Cou	untry?
	with with	0	335 South Seton A	Wenile	21	727			U.	S.A.	
	ns 2:	Funerai		. Was Decedent Ever in U.S.	13 Was Deced	lent of Hi	spanic Origin? (Spo n, Mexican, Puerto	ecity Yes or No-	14. F		ncan Indian,
0	ter f	Fur	1 Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	1 ☐ Yes 2	**	Specify:	rilouri, otoly	]	city:	,, 010.
3	urs a	Ď	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 105 4	2 LI NO	Зреспу.			Whi	
7	within 72 hours after death with the Maryland ene. Itan "natural" or Itams 23a or 28a-f ahow he Maulical Examinar must be notified at	Completed	15. Decedent's Educa (Specify only highest grade		. Decedent's Usua (Give kind of wor	al Occupa rk done d	ition luring most of work )	ing		f Business/I	•
Š	Marin 7	pie	Elementary/Secondary (0-12)	College (1-4or 5+)	'life. DO NOT us	se retired,	)				Community
Maryland 21215-0036	gien gien	5		College 5+	Teacher	•					of Charity
2	e filed a! Hygi I other vent,	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Name	a (First, Middle, r	walden Sun	iame)	
<u>a</u>	ould be filed wit Mental Hygiene Marked other the Natic avant, the	10	Charles Arnold Se	enner				arie Has			T. O. d.)
a D	2 should be filed within 72 hours after death with the Marylan and Mental Hygiens.  Is marked other than 'natural', or itams 23a or 28a-1 show armatic event, the Mudical Examinar must be notified at		19a. Informant's Name/Relationship (Typ	e, Print) 191 Prior			and Number or Run				
Σ	and and n 27		Mother Sup Sister Camilla H	irant			n Avenue,				1727 Town, State
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 is marked any injury or other traumatic a <u>once</u> .		20a. Method of Disposition  1   ■ Burial 2 □ Cremation 3 □ Re	moval from State	of Disposition <i>(Nar</i> <b>05@010</b> 00500 <b>ncial</b> Hol	ther plac	e)				
Ĕ	Pag nent int: I		4 Donation 5 Other (Specify)	Provi	ncial Ho	use	8/7/2	8008	Emmit	sburg	J, MD J Home
<u>=</u>	pertruit.		21. Signature of Funeral Service License	1	22. Name an	Modres	ss of Facility Mye n Street,	rs-Durb. Emmitsh	oura.	MD 21	727
0	88558		Haniel C1-1	lages							
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. Do acause on each line.	not enter the mod	le of dyin	g, such as cardiac	or respiratory arr	est,	i	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Kirline y Fo	ailu	e					Zweek
	/Medical		resulting in death)	Due to (or as a consequence	of):		,				
н	Examiner		b.	End Stas	e COL	U Co	al car	UC EK	2		2 413
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events	Due to (or as a consequence	of):						1
	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events c.								
ó	sate be executed physicien and the burial-transit	Ex	resulting in death) Last	Due to (or as a consequence	e of):						
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9	as as	Med	IE ESWALE.								
Вох	death certific e attending p od for use as	N/S	23b. Was decedent pregnant	ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat	th 3⊟Ectopic p	regnancy	/		23d	. Date of de Month	livery Day Year
	that the death cer ed by the attendin detached for use	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 🗷 No	4☐Pregnant at time of death 9☐Unknown	5 Other (se			<del> </del>		1410-110-1	,
0	t the by th tache	hys	9 ☐ Unknown					an Didu			a the cause of death?
	tw requires that the s been signed by th g should be detache	Ş.	Part II. Other significant conditions con	tributing to death but not resulting	in the underlying	cause giv	en in Part I.				o the cause of death?
of Vital Records	an sig	ed						1 D Y	es 2	10 3[]	robably 4 Unknown
S	S C	pie						24a. Was autop		prior to	utopsy findings available completion of cause of
æ	╸ᅩᄣ	Completed						perfo	med?	death? 1 ☐ Ye	s 2 🗆 No
tal	ician: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Dea	th (Check only o	ne)		
<u>&gt;</u>		To B	examiner? 1 ☐ Yes 2)☑ No	ospital: 1 ☐ Inpatient 2 ☐ ER/0	Outpatient 3 D	OA Oth	ner: Nursing H	ome 5 ☐ Resid	dence 6	Other (Spe	ecify)
	g Phys er this eral di	- L	27. Manner of Death	28a. Date of Injury 28b (Month, Day Year)	. Time of Injury	28c. Injui Wo	ry at	28d. Describe h	now injury o	ccurred	
<u></u>	Attending ir death. sctor: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation	(Martin Day 1989)	M		Yes 2 □No				
Division	Atte	if c	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factor	ry, office		28f. Location (S City or Tox		lumber or F	Rural Route Number,
Ö	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:									
	Hospital		29a. Certifier Certifying Phys	sicien: To the best of my knowled	lge, death occurred	d at the ti	me, date and place	, and due to the	cause(s) ar	nd manner a ace, and du	as stated. re to the cause(s)
	hs Hi n 24 hs Fi oletel	Medical	one)	and manner stated.							
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	0.000	21 20 25	c. Licen:	se nu <i>m</i> ber				nth, Day, Year)
	11/1/		ponikal. kh	surper for [	apo	40	0440	5)	58C	3-5	2008
	My		30. Name and address of person who co	mpleted cause of death (Item 23a	a) (Type, Print)	17	21-123	West	- in	an	5702)
	[		1500 Ta V. RRE	mfta-fort	TERP.	QE	imm.	18 ba	18,6	MI	1777
	St	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	.0			ı	U		
	Regis	trar	AUG 0 6	2008 Messes 1	EST A	10					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 8 **Physician** 2008 11:45 A M William M. Showacre /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Marley Neck Health & Rehab. Center Glen Burnie If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/26/1921 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Maryland 87 Director 232-44-7673 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 21s marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he published once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 No Directo Maryland Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21401 3 N. Southwood Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Pyes 2 □ No If Yes, Give Year or Dates: WW II 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lieutenant Colonel United States Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Genevieve Farnsworth William Russell Showacre ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johanna M. Thompson/Friend 632 Basin Way, Arnold, Maryland 21012 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 08/07/2008 Edgewater, Maryland Kalas Crematory 5 Oyner (Specify) 4 Donation 21. Signature Funeral 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 Pril E er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Onset and Death andrac I media Cause (Final dis se or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending g IF FEMALE 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy pertormed? Yes 2 No 1 ☐ Yes ¹2 ☐ No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? after death.

I Director: After the in by the funeral 27. Manner of Death Certification: Injury 1 Watural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 T Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral L completely filled 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a title of certifier D57028 08-06-08 85 d address of person who completed cause of death (Item 23a) (Type, Print) 600 Ridge Aditya Annapolis MD 21401 Chopra D Wenue #231

Registrar

State

31. Date filed (Month, Day, Year)

AUG 0 8 2008

DHMH 17 Rev 1/2001

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 2008 August 5, 9:10 P M Winifred Z. Spitalnick /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Village Health Care Center Montgomery Village Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□ M 2X F July 6, 1923 Connecticut 048-10-1263 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marchael Examiner must be rediffed at once. 1 ☐ Yes 2 No Director Palm Beach Delray Beach FL10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 33484 USA 5325-B Privet Place Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. ģ White 3 □ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Ziff Bertha Simons ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8813 Cochrane Court Gaithersburg, MD 20879 Mark Spitalnick/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 08/08/08 Beltsville, MD Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service License MO1251 Beverly L. Heckrotte, P.A. Clarksville 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) necolasm **Physician** SODNagcal /Medical Due to (or as a consequence of): JoochJacidism **Examiner** Sequentially list conditions, if any, leading to initirediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Diapster attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f I∐Yes 2XNo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ ₩ 5 24a. Was an autopsy performed? s certificate has I irector, page 2 s 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death

1 Natural
2 Accident 28d. Describe how injury occurred Injury 5 ☐ Pending investigation in 24 hours are, the Funeral Director: Af 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide determined 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DYIIGZ MD August 7

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 195 50 GaNH WD 31. Date filed (Month, Day, Year)

AUG 1 1 2008

Doctors Drive Germanteur

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Marylar		tificate o			Reg. No.	2008	27151
	Physicia	an	Decedent's Name (First, Middle, Last)	77	G 1.1			Date of Dea     Month	Day	Year	3. Time of Death
Æ	/Medic	al	Anna	Virginia	Smith			July 2		008	10:50 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give st	reet and number)		Cumbe	n, or Location of Death	1		County of Deatl .11egany	
200	Funeral	-e ! -	Memorial Hospital  5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye	ear If Under 24 Hrs.	8. Date of Birt		9. Birtl	hplace (State or Foreign
	Director		217-10-4270	M 21XF 92	Yrs.	Months Da	ys Hours Min.	11/06/	1915		yland
	yland now at		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
	e Mar a-f st	ctor	MD Alle	gany	Cu	mberlar	nd				1√TYes 2□No
	th with the 23a or 28 ist be no	al Director	10e. Street and Number 1120 Shades Lane	е		10f. Zip Cod	21502		10g. Citiz	en of What Co USA	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	by Funeral	11. Marital Status	2. Was Decedent Ever in U Armed Forces? 1		Was Decedent If Yes, specify 0 1 ☐ Yes 2 ☑	of Hispanic Origin? (S Cuban, Mexican, Puert No <i>Specify:</i>	pecify Yes or No o Rican, etc.)		4. Race - Ame Black, White Specify:	
2-0	72 ho natur ileal I	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	1 (Give	dent's Usual Od	one durina most of wor	king I	16b. Kir	nd of Business/	Industry
121	vithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use re	tired)		G.		
2	filed within the Hygiene.  other than sent, the My		12 17. Father's Name (First, Middle, Last)		<u> </u>	o-Owner	18. Mother's Nan	ne (First, Middle,		eenhous Surname)	e
Maryland	be d od eve	To Be		lliam	Walbur	'n	Anna			arth	Horstman
ary	2 should be and Mental is marked aumatic ev	F	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailir	ng Address (St	reet and Number or Ru	ıral Route Numb	er, City o	Town, State, 2	Zip Code)
	12 # d		Charles L. Smith /				les Lane, (				
Baltimore,	ges 1 a t of Hea if Item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery, crei	sition (Name o matory or other	place)	Date		cation - City or	
tim	t. Pag tment tant:		4 □ Donation 5 □ Other (Specify)	Hi			ial Park 0				
Bal	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		21. Signature of Funeral Service Licerse	dam	2	404 Dec	atur Stree	t, Cumbe	rlan		Home, P.A. 21502
*6			23a. Part : Enter the disease, or complice shock, or heart failure. List only on	cations that caused the dear e cause on each line.	th. Do not ent	er the mode of	dying, such as cardiae	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Urose							hours
	/Medical Examiner			Due to (or as a consec	quence of):						
		Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):						
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause)								
90,	icate be executed physician and s the burial-transit	ŭ	resulting in death) Last	Due to (or as a consec	quence of):						
68760,	cate b	edical	d								
.O. Box 6	ath certif attending or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	⊒Ectopic pregn ⊒ Other <i>(sp</i> ecif			2	23d. Date of de Month	livery Day Year
Δ.	res that the de signed by the a be detached t		Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying caus	given in Part I.	23e. Did t	obacco u	se contribute to	the cause of death?
rds	w requires been sign should be	ed by						1 🗆	Yes 2	No 3□P	robably 4 □Unknown
or Vital Records,	The law re te has bee age 2 sho	Completed						24a. Was auto perfo 1∐ Yes		24b. Were at prior to death?	utopsy findings available completion of cause of
ita	Physician: The la r this certificate has ral director, page 2	Be C	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only			
Σ	Physician: r this certifica ral director, p	70	1 ☐ Yes 2 No		ER/Outpatier			lome 5□Resi			ecify)
ion	ng fte		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 28c.	Injury at Work? 1 ∐ Yes 2 ∏ No	28d. Describe	how injur	y occurred	
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Spec	nome, farm, str ify)	reet, factory, of	fice	28f. Location ( City or To	Street an wn, State	d Number or R )	ural Route Number,
	e Hospi 124 hour e Funer letely fills	Medical (		ician: To the best of my kn er: On the basis of examin and manner stated.							
	To th Withir To th comp	Me	29b. Signature and title of certifier		1	29c. Li	cense number			te signed (Mon	
	5		Bull	Calke	_ >h		54411		Ju1	y 28	, 2008
	nes		30. Name and address of person who co Beverly M. Calkins	mpleted cause of death (Ite	m 23a) (Type;	Print) spital	Medical Bl	dg., Cu	mber	land, M	D 21502
11	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Sign		arle				<del></del>	

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day 3 1 2008 5:20 A M July Lillian F. Tyler

7. Age (In yrs. last birthday)

87 Yrs.

4b. City, Town, or Location of Death

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Onth, Day, Sept. 11

Min. Sept

Crofton

4c. County of Death

1920 N.

Anne Arundel

9. Birthplace (State or Foreign Country)
N. Carolina

	Physici /Medic Examin	a
I	Funeral	

4a. Facility Name (If not institution, give street and number)

5. Social Security Number

212-24-8433 Usual Residence of Decedent

Crofton Convalescent & Rehab

6. Sex

1 M 2 F

	aryland show		10a. State	10b. County		10c. City	, Town or L	ocation				-		10d. Inside City Limits
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	the 28a	rec	10e. Street and Nun					10f. Zip Code	)			10g. C	Citizen of What Co	ountry?
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	ms 2	Jera	11. Marital Status		12. Was Decedent B	ver in U.S	S. 13	. Was Decedent o	f Hispanio	c Origin? (Specif	fy Yes or No	)-	14. Race - Ame	
(0	riter of	Fur		ed 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N	lo		If Yes, specify Co		,	can, etc.)		Black, Whit	
036	urs a	by	3 🗆 Widowed	4X Divorced	If Yes, Give Year or Dates:			1⊡Yes 2⊡XN	o Spe	cify:			Specify: B	lack
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Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Fu	1				AMName Rocked						
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tal	an: The tificate or, pag	ပ္	25. Was case referr	red to medical					26 P	Place of Death (	1 ☐ Yes		lo 1∟Ye:	s 2 Mo
>	ding Physiclan: ih. After this certifica funeral director, p	o B	examiner? 1 ☐ Yes 2 ☐		Hospital:	nt 2 □ !	ER/Outpatio	ent 3 DOA	hhor:	/			6 □Other (Spe	ecify)
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o	Attending ir death, ector: After by the funer	atio	1 ☑ Natural 2 ☐ Accident	5 Pending investigation	(Month, Da) n	(, rear)	Injury		′orḱ? ∐Yes 2	2 □No				
Division	or Attender	ific	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	e 28e. Place of Inju	ry - At ho	me, farm, s	treet, factory, offic	e	28	f. Location (	Street &	and Number or F	Rural Route Number,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 11:09 A M 2 August 2008 Walter Raymond Wallace, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 523 Quarrier Ct. Carroll Westminster If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 7, 9. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** XIX M 2 D F 85 Director 216-10-9648 Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 11X7Yes 2 □No Director MD Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 523 Ouarrier Ct. Westminster Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🔯 No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 □ Divorced Year or Dates: WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 h (Give kind of work done during most of working life. DO NOT use retired) Toll Facilities Elementary/Secondary (0-12) College (1-4or 5+) 12th Major and Commander Police Force permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygid Important: If item 27 Is marked other I any Injury or other traumatic event, ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Andrew Alex Wallace Marv Emma Huff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 760 Mulligan Lane Westminster, MD 21158 Keith Wallace (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Park 8/6/2008 Sykesville, MD Burrier-Queen Funeral Home and Crematory, P. 1212 W. Old Liberty Rd. Winfield, MD 2178/Liberty Rd article and accordance of dying, such as cardiac or respiratory arrest. 21. Signature 22. Name and Address of Facility Interval Between Onset and Death Immediate Cause (Final Few Years **Physician** CAD disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Few Years NIDDM Type II Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Dyslipidemia Few Years attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ed by the a 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an rector, page 2 s autopsy 1□ Yes 2√XNo To the Hospital or Attending Physician; funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home STResidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 ☐ Accident Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director; A completely filled in by the f 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide XXcertifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner stated. 29a. Certifier Medical investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe D37949 August 4, 2008 WI 10+NA 30. Name and address of person who completed use of de (Item 23 ype, Print)

State Registrar Alexander Bogdaschewskyi

31 Date filed (Month, Dav. Year)

32. F

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2008

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

MD 2 Locust Lane Suite 201 Westminster, MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Z:34AM 2008 Wachter 6 lerie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner of Maryland Medical Center Baltimore University If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, March 31, Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Months Min. Year) 1953 Country) New Jersey 1 □ M 2 🖺 F 55 Vrs 568-74-4476 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Cecil North East 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21901 49 Clearview Avenue U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐Yes 2 No If Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No White Completed by 3 Widowed 4 Divorced Year or Dates: "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) Dove Productions than Elementary/Secondary (0-12) College (1-4or 5+) New Jersev Owner/Operator one year other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be marked Frances Sole Leroy Brown ို traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2 21901 John T. Wachter 49 Clearview Avenue, North East, Maryland 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Important: If it any injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 08/10/08 West Chester, Pennsylvania R.A. Ferris & Co., Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig. <sup>22. Name and Address of Facility</sup> Lee A. Patterson & Son Funeral H Perryville, Maryland 21903-0766 ure of Funeral Se vice Licensee Home, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Myeloid Leukemia /Medical resulting in death) Due to (or as a onsequence of): Examiner Multiorgan Failur Sequentially list conditions Due to (or as a whisequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed and Due to (or as a consequence of) burial-t Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a ☐Yes 2 No Ö 9 Unknown 9 Unknown ٣. The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been si should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed 1 Yes 2 ANo certificate 1 ☐ Yes 2 ☐ No of Vital the Hospital or Attending Physician: hin 24 hours after death.

the Funeral Director: After this certifica mpletely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 Mo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only

State

2

22 S. Green St. Baltimore MD et of Medicine Lersy Vau an MD 31. Date filed (Mor 2008

29b. Signature and title of certifier

30. Name and address

and manner stated.

ersen who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

1366646697

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** BERNARD 24 2008 М IRA WENRICK 07 1220 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ★ M 2 🗆 F 234-40-3173 80 26,1928 WEST VIRGINIA Director APR. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 27 No WV Director MINERAL RIDGELEY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number R.R. 4, BOX 17 U.S.A. 26753 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. <sup>2□ No</sup> WWII & within 72 hours after Yes 2 1 Never Married 21 Married "natural", or 1 ☐ Yes 2 X No Specify. þ Specify: 3 Widowed 4 Divorced KOREA WHITE Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) filed withir Hygiene. other than CONTRACTOR CONSTRUCTION UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be 1 MARTIN WENRICH DAISY (UNKNOWN) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 19a. Informant's Name/Relationship (Type. Print) VALERIE WENRICK / DAUGHTER Health tem 27 R.R. 4, BOX 17, RIDGELEY, WV 26753 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages Department of Important: If it any Injury or o once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CUMBERLAND CREMATORY 07/25/2008 CUMBERLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A.
202 GREENE STREET, CUMBERLAND, MD 21. Signature of Funeral Service Licens 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PROBABLE MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPOKALEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusity (or as a consequence of) Examiner law requires that the death certificate be executed CARDIOMYOPATHY use as the burial-tran and Due to (or as a consequence of) attending physician for use as the buria ATRIAL FIBRILLATION Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ACUTE RENAL FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ANOXIC ENCEPHALOPATHY page 2 s DEHYDRATION 1☐ Yes **2**√□ No or Attending Physician; uneral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 □ EB/Outpatient 3 □ DOA Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 XNatural 5 Pending investigation Injury 1 □ Yes 2 □ No I Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3∏ Suicide filled in by determined 4 Homicide within 24 hours a To the Funeral I To the Hospital l 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D00 666 101

State Registrar

31. Date filed (Month, Day, Year) JUL 2 8 2008



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Saltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:28a M Leona Carter Abrams 8/22/08 /Medical 4a. Facility Name (If not institution, give street and number) NIA 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 1 2 Month | 20 0 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) MD 1 □ M 2 1 F Months Days 220-14-1793 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Musical Exp. interminat be notified at MD N/A Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 4801 Herring Run Drive 21214 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. African Specify: American 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) City of Balt. Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence E. Carter Nannie B. Carter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Abrams/son 4319 Marble Hall Rd,Balt.,MD 21218 permit. Pages 1 and Department of Healt Important: If Item 2: any Injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrish Forest VA 8/29/08 Owings Mills, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hari P. Close F. Svs. PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Fu eral Sevice Licensee 23a. Part 1. Enter the diseas Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Renn **Physician** disease or condition resulting in death) deup /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any sealing to the claim cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 ☐ Yes 2 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No Hospital: gother (Specify WSOVO မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation lospital or Attendi I hours after death. 'uneral Director: A ely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 2 Charles St Toward no zizas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J-CHARLES

Registrar

State

31. Date filed (Month, Day, Year)

AUG 25

2. Registrar's Signature

			e Type or Prii State of M	nt in Black in aryland / Dep					•
		for State Registrar			rtificate of			Reg. No 2 0 0 8	3 27157
		1. Decedent's Name (First, Middle,	Last)				2. Date of Dea Month	ath Day Yea	3. Time of Death
Physic /Med		Judy Ann Aberna	thy Arnold				August	22, 2008	2:19 P M
Exam		4a. Facility Name (If not institution,	give street and number)	)	4b. City, Town, o	r Location of Deatl	n	4c. County of De	eath
		Greater Baltin  5. Social Security Number		1 Center ge (In yrs. last birthday	Towson	n If Under 24 Hrs.	8. Date of Birt	Baltimo	
Funera Directo		264-68-9039	1 □ M 2/□XF	63 Yrs.	Months Days	Hours Min.	04/04/	7 Year) 1945 Te	Birthplace (State or Foreign Country) ENNESSEE
land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
Mary -f sh	ţ	Maryland Baltim	ore	Essex					1 □Yes 2 XNo
h the	irec	10e. Street and Number		<u></u>	10f. Zip Code			10g. Citizen of What	Country?
th wit	<u>a</u>	1000 Franklin A	venue, Apt.	307	2122	21		U.S.A.	
if e, IVIAL YIATLA KILLID-UOOO s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Nedical Examines must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces  1	Ever in U.S. 13. No	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 No	Hispanic Origin? (S an, Mexican, Puerl Specify:	specify Yes or No- to Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. White
hour	ed			16a. Dec	edent's Usual Occup	oation		16b. Kind of Busine	
hin 72	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or	5+) (Giv.	e kind of work done DO NOT use retire	during most of word d)	rking		
d with	Son	12		Hom	emaker			Own Home	9
yidilio A. I.A. buld be filed with Mental Hygiene, arked other that atic event, the I	To Be	17. Father's Name (First, Middle, L Luther James Be				Lucill	e Owens	Maiden Surname)	
VICE YICE  12 Should I  2 and Men  7 is marke  traumatic	1	19a. Informant's Name/Relationshi						er, City or Town, Stat	
of C, Mic.		Carl Abernathy	(Husband)				Apt. Bo,	20c. Location - City	e, Md. 21222
Dallinofe, permit. Pages 1 and Department of Heal Important: If item 2 any injury or other		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Sp		Holly Hi	osition (Name of ematory or other place of 11 Mem. C	ce) Sard 08/2		•	, Maryland
Deart permit. Depart Import any inj	S S S S S S S S S S S S S S S S S S S	21. Signature of Funeral Service t			1407 Old	Eastern	Avenue,		ryland 21221
Physiciar	8 7	23a. Part 1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition	nly one cause on each I	d the death. Do not el line. SPIRATO			c or respiratory a	rrest,	Approximate Interval Between Onset and Death
/Medica	_	resulting in death)	Due to (or as	s a consequence of):					
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be executed ician and burial-transit	xan	that initiated events resulting in death) Last	C	s a consequence of):	175				-
ate be ex hysician the burial	20	į į	La. 5E	PS15 5	NDRON	1E			
ath certificat	/Mec	IF FEMALE:	23c. If yes, outcome	e of pregnancy				23d. Date of	delivery
the death	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		at time of death 5	☐ Ectopic pregnand ☐ Other (specify) _	cy		Month	Day Year
law requires that as been signed to 2 should be deta	þ	Part II. Other significant condition			underlyi <b>n</b> g cause gi	ven in Part I.	23e. Did 1		e to the cause of death?  ] Probably 4 ☐ Unknown
he law rece has bee tge 2 shot	Completed	NEUROP,	17744					psy prior prmed? deat	autopsy findings available to completion of cause of h?
VICAL iclan: T certificat ector, pa		25. Was case referred to medical	1			26 Place of De	1 □Yes ath (Check only o		Yes 2□No
ysicte ysicte is cer direct	To Be	examiner? 1 ☐ Yes 2 No	Hospital:	tient 2 🗆 ER/Outpati	ent 3 □ DOA Oti	har:		idence 6 ☐Other (	Specify)
tending Phy death. tor: After this	ıtion: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investige	28a. Date of In (Month, D	jury 28b. Time	of 28c. Inju		T	how injury occurred	
Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. From a first death. Fruneral Director: After this certificate has been signed by the attending physician and etel filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	20e. Place of it	njury - At home, farm, s etc. <i>(Specify)</i>	street, factory, office	7.	28f. Location ( City or To	Street and Number own, State)	r Rural Route Number,
Hospit 24 hour Funera stely fille	dical (		g Physician: To the bes Examiner: On the basis and manners	of examination and/or					

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

08-22-2008 TOWSON, MD

Schwartzmp 6535 worth Charles St Ste 550

5 2008 32 Registrar's Signatur pour

DHMH 17 Rev 1/2001

and 2 should be filed within 72 hours after death with the Maryland auth and Mantal Hygiene.  To Be Completed by Funeral Director  To Be Completed by Funeral Director	1. Decedent's Name (First, Middle, Last Mary Barnes 43.09 Independence 5. Social Security Number 6. S 5.77-46-2583  Usual Residence of Decedent 10a. State 10b. County MD Montgome 10e. Street and Number 4309 Independence 11. Marital Status 1 Never Married 2 Married 3 Widowed 15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 11th 17. Father's Name (First, Middle, Last) Thomas Edward 19a. Informant's Name/Relationship ( Mary C. Whittak 20a. Method of Disposition 1 \$\mathbb{R}\$ Burial 2 \$\mathbb{C}\$ Cremation 3 \$\mathbb{C}\$	St.  ex 7. Age (  M 2 F 7:  2 Young  St.  12. Was Decedent Ev.  Armed Forces?  1   Yes 2 F   No.    Young	Oc. City, Town or Le Rockvill er in U.S. 13.  16a. Dece (Give life). Wai	Rockvil  Rockvil  If Under 1 Year  Months Days  Docation  e  10f. Zip Code  20853  Was Decedent of Hill Yes, specify Cuba  1 Yes 2 No	Location of Death  1e  If Under 24 Hrs. Hours Min.  Ispanic Origin? (Specin, Mexican, Puerto R Specify:  attorn	B. Date of Birth (Month, Day, Ye L 2/24/193	Citizen of What Cou  USA  14. Pace - Ameri Black, White, Specify: B. b. Kind of Business/Ir	ny place (State or Foreinity)  1 and  10d. Inside City Limi  1 Yes 2 N  ntry?  can Indian, etc.  Lack  idustry
should be filed within 72 hours after death with the Maryland and Mantal Hygiene.  In marked other than "natural; or items 23s or 28s-f show the marked other than "natural; or items 23s or 28s-f show the marked other than "natural; or items 23s or 28s-f show that a constitution of the marked of	4309 Independence 5. Social Security Number 6. S 577-46-2583  Usual Residence of Decedent 10a. State MD Montgome 10e. Street and Number 4309 Independence 11. Marital Status 1 Never Married 2 Married 3 Widowed 15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 11th 17. Father's Name (First, Middle, Last) Thomas Edward 19a. Informant's Name/Relationship ( Mary C. Whittak 20a. Method of Disposition	St.  ex 7. Age (c. 7.	3 Yrs.  Oc. City, Town or Lo  Rockvill  er in U.S. 13.	Rockvil  Rockvil  If Under 1 Year  Months Days  Docation  e  10f. Zip Code  20853  Was Decedent of Hilf Yes, specify Cuba  1 Yes 2 No  Indent's Usual Occup; a kind of work done of DO NOT use retired	Location of Death  1e  If Under 24 Hrs. Hours Min.  Hours Min.  Jispanic Origin? (Specin, Mexican, Puerto Respectly:  ation during most of working)	B. Date of Birth (Month, Day, Ye L 2/24/193	4c. County of Death  Montgome: 9. Birth Cou 34 Mary  Citizen of What Cou  USA  14. Race - Amen Black, White, Specify: B. b. Kind of Business/Ir	place (State or Foreintry)  1and  10d. Inside City Limi  1 Yes 2 N  ntry?  can Indian, etc.  Lack
should be filed within 72 hours after death with the Maryland and Manal Hygene.  In Market other than "natural; or items 23a or 28a-f show paint umatic event, the Midcal Examinat must be natified a parallel or the Midcal Examination of the confidence of the Midcal Examination of the confidence of the Midcal Examination of the Completed by Funeral Director of the Midcal Examination of the Midcal Examination of the Maryland of the Midcal Examination of the M	5. Social Security Number 5. 77-46-2583  Usual Residence of Decedent 10a. State 10b. County MD Montgome 10e. Street and Number 4309 Independence 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 11th 17. Father's Name (First, Middle, Last) Thomas Edward 19a. Informant's Name/Relationship ( Mary C. Whittak 20a. Method of Disposition	ex 7. Age (	3 Yrs.  Oc. City, Town or Lo  Rockvill  er in U.S. 13.	If Under 1 Year Months Days  Docation  e  10f. Zip Code 20853  Was Decedent of Hilf Yes, specify Cuba 1 Yes 2 No  Indent's Usual Occup; In Month of Work done of DO NOT use retired	ispanic Origin? (Specin, Mexican, Puerto R Specify:	10g. 10g. 10g.	Octizen of What Cou  USA  14. Race - Ameri Black, White, Specify: B: b. Kind of Business/Ir	place (State or Foreinty)  1and  10d. Inside City Limi  1 Yes 2 N  ntry?  can Indian, etc.  Lack  idustry
should be filed within 72 hours after death with the Maryland and Mantal Hyglene.  In marked other than "natural; or items 23a or 28a-f show umatic event, the Madcal Examinating that be halflisted at To Be Completed by Funeral Director	10a. State MD Montgome 10a. Street and Number 4309 Independence 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 11th 17. Father's Name (First, Middle, Last) Thomas Edward 19a. Informant's Name/Relationship ( Mary C. Whittak 20a. Method of Disposition	ery  2. St.  12. Was Decedent Ev. Armed Forces? 1	Rockvill er in U.S. 13.  16a. Dece (Give life).  Wait	e 10f. Zip Code 20853 Was Decedent of Hilf Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (Spec n, Mexican, Puerto R Specify: ation during most of workin.	10g.	Citizen of What Cou  USA  14. Race - Amen Black, White, Specify: B	10d. Inside City Limi 1★2 Yes 2 □ N ntry?  can Indian, etc.  Lack idustry
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it item 27 is marke or other treumetic	19a. Informant's Name/Relationship ( Mary C. Whittak 20a. Method of Disposition	Type, Print)	105 14-75		D	_		
if item 27 is or other trail	20a. Method of Disposition	er/ Sister	19b. Maili	ing Address (Street a	Rosetta and Number or Rural		merville lity or Town, State, Zi	p Code)
or off			638 F	Rock Creek	Church R	d. NW.Wa	shington,	DC 20010
7 7 5 E	* 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		matory or other plac	e)		c. Location · City or T ure1, Mary	
permit. Departminimporta sny inju	21. Signature of Funeral Service Licen		2	2. Name and Addres		nson & J	enkins Fur	
Physician	23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition		ne death. Do not en		g, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
Examiner	resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying	b. End	consequence of):	Pulmo	nary I	isease		
ans ans	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Priv	mary consequence of): ronic H	Pulmon y poxemia	ary st	ty pert iratory	ension. Failure	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	pregnancy	□Ectopic pregnancy			23d. Date of delive Month	very Day Year
uires that the signed by the detailed by detailed by Ph	Part II. Other significant conditions of Diabete S, Chroni						cco use contribute to	the cause of death
The law requires the law requires the law been signed and page 2 should Completed	disease, Hy	/				24a. Was an autopsy performed	d? prior to co	opsy findings availa ompletion of cause 2 \( \text{No} \)
hysician: this certifical director. To Be	25. Was case referred to medical examiner? 1  Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day )	2 ER/Outpatie	of 28c. Injury Work	y at 2		ce 6 Other (Specinjury occurred	(fy)
tal or Attending F is after death. al Director: After ed in by the funers  Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	9 Ogo Blace of Injure	/ · At home, farm, st (Specify)		Yes 2 □No 2	Bf. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
Hospi 24 hours Funer etely fill dical	29a. Certifier (Check only one)  Certifying Ph	ysician: To the best of niner: On the basis of e and manner state	xamination and/or in	th occurred at the tin rvestigation, in my o	ne, date and place, a pinion, death occurre	nd due to the caus d at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To the within To the compl	29b. Signature and title of certifier	fleha	<u></u>	29c. Licenso	e number 4529 (		Date signed (Month	
3	30. Mme and address of person who	completed cause of dea	th (Item 23a) (Type AS . 108	12			ensington	

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2008 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** JOHN WESLEY BRAMBLE August 24, 2008  $A^{M}$ 1:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Greater Baltimore Medical Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year, 8/20/1921 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours Min X M 2 F MARYLAND 87 220-09-5164 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c City Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If leave 23s or 28a-f show limportant: If leave 27s marked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, in "Adding Earl", and to nother traumatic event, in "Adding Earl". Director 1 ☐ Yes 2X No MD BALTIMORE GLEN ARM 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 4200 LONG GREEN ROAD 21057 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. MYYes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: WHITE ð 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired)

OPERTOR & FINANCIAL INVESTOR Elementary/Secondary (0-12) College (1-4or 5+) **BGE** 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ GEORGE BRAMBLE MAY MINCH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WESLEY W. BRAMBLE/SON 4200 LONG GREEN ROAD GLEN ARM, MD 21057 20b. Place of Disposition (Name of cemetery, crematory or other place)
DULANEY VALLEY MEM. 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial, 2 ☐ Cremation 3 ☐ Removal from State 8/30/2008 COCKEYSVILLE, MD 4 Donation 5 Other (Specify) GARDENS 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, F.A. 21. Signature of Fun ral Service Li 8521 LOCH RAVEN BLVD. TOWSON. MD 23a/Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only doe cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypoxic Respiratory Failure
Due to for as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if a.r.y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last resolution to uti Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical the IF FEMALE: for use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. I signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Smossig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed?

1 Yes 2 XNo certificate Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ After this 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Deatl 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifiei Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 20064203 8006 1 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beffinave Medical Center HmuMinn Creaky 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 2 5 2008

DHMH 17 Rev 1/2001

SRAMBLE,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-06345 State of Maryland / Department of Health and Mental Hygiene 2008 Richard Mark Burkhardt Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month August 19, 2008 RICHARD MARK BURKHARDT **Medical Examiner** 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number **Baltimore** 134 S. Patterson Park Avenue If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 02/01/1951 57 Director 1 X M 2 295-48-5467 Yrs Usual Residence of Decedent 10c, City, Town or Location 10b. County 10a. State

1945 hrs 4c. County of Death 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or oreign Country) WEST VA 10d. Inside City Limits 1 Yes 2 No BALTIMORE 23a or 28a-f show notified at once, MD death with the Maryland rector 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number USA 21231 134 S. PATTERSON PARK AVE. Ö 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces 1 Never Married 2 Married 2 X No Yes WHITE Specify: Yes 2 No specify. Divorced f Yes, Give Year within 72 hours after 3 Widowed δ, 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed nit. Pages I and 2 should be filed within 72 h, arthment of Health and Mental Hygiene. sortant: If item 27 is marked other than "n rry or other traumatic event, the Medical E. College (1-4 or 5+) Elementary/Secondary (0-12) GENERAL CONSTRUCTION MD 21215-0036 5+ CONTRACTOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARY ADAMEK RICHARD O. BURKHARDT Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4890 13th LANE VERO BEACH, FLORIDA 32966. REBECCA COLTON(SISTER) 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 08/24/2008VERO BEACH,FLA. CRESTLAWN Donation 5 Other Specify 22. Name and Address of Facility permit. Departm Imports 21. Signature of Funeral Service Licenses W. JENKINS & SONS CO. YORK RD MONKTON, MD. 2 aus HENRY 16924 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** veen Onset and failure. List only one cause on each line Death Medica a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed Physician/Medical AMENDED attending physician a UNPENDED law requires that the death certificate be 23d, Date of delivery Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy Day 3 Ectopic pregnancy Month 23b. Was decedent pregnant in the Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown isigned by the atte Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 V Unknown ð Division of Vital Records, P. tal or Attending Physician: The law requires th chronic alcohol abuse Completed 24b. Were autopsy findings available 24a. Was an has been s prior to completion of cause of autopsy death? performed? 2 No ✓ Yes 2 No 1 V Yes page certificate 26.Place of Death (Check only one) 25. Was case referred to medical director, Be examiner? Residence 6 V Other: Scene Hospital: Nursing Home 5 ER/Outpatient 3 Inpatient 2 this 1 V Yes ၉ 28d. Describe how injury occurred 28c. Injury at Work 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury funeral After 27. Manner of Death Certification: 1 Yes 2 1 V Natural To the Hospital or Attendil within 24 hours after death.
To the Funeral Director: Pending Hospital or Attend 24 hours after death. the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. filled in by Could not be or Town, State) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie August 20, 2008 O.C.M.E. 30. Name and admiss of person who completed cause of death (Item 23a) 0 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Pamela E. Southall, MD Registrar's Sign 31. Date filed (Month, Day, Year) 2008 State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Arthur John Brett 21, Aug 2008 P 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Mount Airy 1115 N. Main St. Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 9 / 28 / 1 9 3 1 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1**½** M 2□ F 76 391-28-7116 WI Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No Director MD Mount Airy Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1115 N. Main St. 21771 United States Funeral Was Decedent Ever in U.S. Ayred Forces? 1952

1 X Yes 2 No 1954

If Yes, Give 1954 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married Married 1 ☐ Yes 2X No White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Social Security Admin Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Brett <u>Geneviene Clark</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1115 N. Main St. Mt. Airy, MD 21771 19a. Informant's Name/Relationship (Type. Print)
Mary Jane Brett (wife) Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Pine Grove Cem. 8/25/2008 Mt. Airy, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Purrier-Queen Funeral Home and Crematory, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approx. Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stage Physician LIVES Disease month /Medical Due to (or as a cons-unence of): Examiner Alcoholic Se uentiall, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 drknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perforn certificate To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 21 Ng Other: 4 \subseteq Nursing Home Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation **Natural** 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 22, 2008 D0059423 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6030 Dubreak Circle
32 Begistrar's Signature 4150-236 Clarkeville, MO 21029 Feinberg 31. Date filed (Month, Day, Year) State Registrar AUG 2

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**ORIGINAL** 

		•	1- For amend item State of Maryland Department of Death and Mental Hygiene Certificate of Death Reg. No. 2008 2716
	Physici	an	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year A:KAM
-	/Medio		Mary C. Coster  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
*	Funeral		Baltimore Washington Medical Cntr.  Glen Burnie  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.   8. Date of Birth (Month, Day, Year)   9. Birthplace (State or Foreign Country)
	Director		121-18-1105   1 M 2 PF   85   Yrs.   Months   Days   Hours   Min.   (Month, Day, Tear)   Country)   Usual Residence of Decedent
	yland		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	8a-fs	Director	Maryland Anne Arundel Glen Burnie
	with th	I Dir	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  300 King George Drive 21061 USA
	ems 2	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Modral Examinar mant by I offined at	þ	1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give 1 □ Yes 2 ☑ No Specify: Specify: White
15-0	"natu	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)
212	d withir giene. r than	dwo	Elementary/Secondary (0-12) College (1-4or 5+)  12 Disabled N/A
	be filectal Hyg	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
Maryland	s should be filed withir and Mental Hygiene. Is merked other than aumatic event, the M	은	Marion LaRose Mary Gillig  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
, ⊠a	127 m		Laura Berrios (Care provider) 300 King George Drive, Glen Burnie, Maryland 21061
Baltimore,	0 - L		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State
Ħ,	Par ner		4 Donation 5 Other (Specify)  Bayview Crematory 08/23/2008 Baltimore, Maryland  21. Signature of Fund Sproce Licensee  22. Name and Address of Facility
Ba	permit. Departr Importa any Inju	1	McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122
	Physician /Medical Examiner	iner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury)
68760,0	The law requires that the death certificate be executed ate has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	edical Examine	Cause (Disease or injury that initiated events resulting in death) Last  C
O. Box	at the death certific by the attending p tached for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   Yes   Yes
rds, P.	w requires that been signed I should be deta	ρĺ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes No 3 Probably 4 Unknown
Vital Records,	i <b>clen:</b> The law re certificate has be ector, page 2 sho	Completed	24a. Was an autopsy findings available prior to completion of cause of death?  1   Yes   2   No   1   Yes   2   No    25. Was case referred to medical   26. Place of Death (Check only one)
$\equiv$	ystclen: is certific director,	To Be	25. Was case referred to medical examiner?  1   Yes
n of	ding Ph h. After th funeral		27. Manner of Death 1 A Natural 5 Pending (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Work?
Division	Attendart dector: by the	Certification	2 Accident 3 Suicide 4 Homicide    No   No   No   No
	the Hospital or hin 24 hours afte the Funeral Dir. mpletely filled in	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
D	To the vithin to the company of the	M	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
	1		30 Name and address of berson who completed cause of death (Item 23a) Type, Brint)  18 DUS UNS. 301 HOSETHA DRIVE, Glen Burne, Ms. 206/.
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 2 5 2008
DU	Registr		LOUND TOO LEADING IN PRINTED

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-06473 State of Maryland / Department of Health and Mental Hygiene 2008 Albert Driscoll, III Certificate of Death Rea. No. 1. For State 2 Date of Death Registrar 1. Decedent's Name (First, Middle, Last) Month Day August 24, 2008 Physician/ 0139 hrs Driscoll III **Medical Examiner** Albert 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Sparrows Point 7306 Geise Avenue 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Country) Maryland Months Hours April 3,1969 39 Director 214-08-7383 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits Oc. City, Town or Location 10b. County 10a, State Yes 2 X No Edgemere Maryland Baltimore 28a-f show 10g. Citizen of What Country? with the Maryland Director 10f. Zip Code 23a or 28a-f notified at o 10e. Street and Number USA 21219 2114 Alma Avenue 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-12. Was Decedent Ever in U.S uneral 11. Mantal Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. nust be Armed Forces? 2 Married 1 Never Married Yes 2X No White Specify: Yes 2 X No specify: 4 X Divorced If Yes, Give Yea more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after near of Health and Mental Hygiene. Widowed 16b. Kind of Business/Industry "natural", is marked other than "natural", atic event, <u>the Medical Examiner</u> 16a. Decedent's Usual Occupation (Give kind of work done ģ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Tattoo Artist than 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joyce Engle Albert E. Driscoll Jr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 8134 Longpoint Road, Dundalk, Maryland Albert E. Driscoll Jr. Father Baltimore, MD it: If item 27 i 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, August 28 20a. Method of Disposition

1 Burial 2 Cremation 3 crematory or other place) Baltimore, Maryland Removal from State 2008 Bayview Crematory Donation 5 Other Specify Connelly Funeral Home Of Dundalk, P.A. Signature of Funeral Service Licenses 7110 Sollers Point Road, Dundalk, MD e, or complications that caused the death, op not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Part I. Enter the disea Physician failure. List only one dause on each line. Death 'Medical a Stab Wound of Chest Immediate Cause (Final disease aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and Physician/Medical AMENDED UNPENDED attending physician for use as the burial 23d Date of delivery requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 V No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available 24a. Was an Completed prior to completion of cause of autopsy death? performed? The law 1 certificate has 1 🗸 Yes 2 ✓ Yes 2 26. Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Division of Vital Other<sub>4</sub> Be Residence 6 Other: Scene Nursing Home 5 ER/Outpatient 3 DOA Inpatient 2 this 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Aug 24, 2008 28b. Time of Injury 27. Manner of Death After Subject stabbed Certification: 0109 hrs Yes 2 V No Natural Pending Director: 28f. Location (Street and Number or Rural Route Number, City 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 7306 Geise Avenue, Sparrows Point, MD Could not be Suicide determined (Specify) Creek 4 V Homicide the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 24, 2008 O.C.M.E. my 30. Name and address of person who completed cause of death (Item 23a) iD 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD Registrar's Signature 31. Date filed (Month, Day, Year) AUG 2 5

DHMH 17 Rev 1/2001 **OCME 2006** 

State Registrar

OCME

ORIGINAL

08-06217 Constantine Dixon

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2008 27165

notal time 2 m		1-For State Criticate Registrar  Certificate	of Death	Reg. No.	
Physici		Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year	3. Time of Death
edical Exami	ner	CONSTANTINE DIXON		August 14, 2008	1023 hrs
in all the		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deatl Baltimore	h 4c. County of Dea	ith
		706 Chestnut Hill Avenue		s. 8. Date of Birth (MM/DD/YYYY) 9. E	hithology (State or
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24Hrs Months Days Hours Mir	Fore	eign
Director		218-72-6343 1XM 2 F 81	Yrs.	APRIL 17, 1927 °	Country) JAMAICA
ž.		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or 1	ocation		10d. Inside City Limits
ow any					1 X Yes 2 No
Maryland 28a-f show 1 at once.	tor	MD BALTIMO	ORE 10f. Zip Code	10g. Citizen of What Co	
ne Maryland or 28a-f sho fred at once,	irec				,
ith th 23a notif	al D	706 CHESTNUST HILL AVE.  11. Manital Status 12. Was Decedent Ever in U.S. 13	21218  3. Was Decedent of Hispanic Origin? ( S	USA Specify Yes or No. 14 Race - Am	erican Indian, Black,
ath w items	Funeral Director	1 Nover Married 2 X Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto		
her de		3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:	Specify: BL	ACK
ours al ntural	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Dec	cedent's Usual Occupation (Give kind of		s/Industry
72 hc n "ns	lete	Elementary/Secondary (0-12) College (1-4 or 5+)	ing most of working life. DO NOT use re	tired)	
5-0036 led within 72 Hygiene. other than the Medical	Completed		RKLIFT OPERATOR	PAPER I	NDUSTRY
215-0036  be filed within 72 hours after death with the Maryland mall Hygiens are the other than "natural", or items 23a or 28a-f she rent, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Last)	18.Mother's Nam	e (First, Middle, Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	DANTEL DIXON  19a. Informant's Name/Relationship (Type, Print )  19b. M	lailing Address (Street and Number or	Rural Route Number City or Town Sta	ate Zin Code)
<b>○</b> 중 절 := :=	To		03 THE ALAMEDA, BA		_
e, MD 21 1 and 2 should Health and Me item 27 is ma		20a. Method of Disposition 20b. Place of D	isposition (Name of cemetery,	Date 20c. Location - City	
Baltimore, ME permit. Pages I and 2 s Department of Health an Important: If item 27 injury or other traum:		Burial 2 Cremation 3 Removal from State	or other place)	/22 /2000 LICODI ALINI	MD
Itin iit. Pa artmen ortan		4 Donation 5 Other Specify: WC 21. Signature of Funeral Service Licensee		/22/2008   WOODLAWN ESLEY CHAVIS, JR.	
Balti permit. Departm Imports		Mosla / Kan wi	AAT	AVE., BALTIMORE,	
Physician		23a. Part I Enter the disease, omplications that cause the death. Do not e failure. List only one cause on each line.			Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Hypertensive Atherosclerotic C	Cardiovascular Disease		Death
LXaIIIIICI		or condition resulting in death)  Due to (or as a consequence of):	-	·	
	-	Sequentially list conditions, if any, leading to immediate b			<u> </u>
	i i	cause. Enter Underlying Cause			
7. 8 2	Examiner	events resulting in death) Last Due to (or as a consequence of):			
xecuted n and l- transit		d. UNPENDED AMENDED			
760, cate be execut physician and he burial - tra	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliv	very
876 tifical ng ph as the		23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregr		Day Year
Box 687 death certific the attending p	Physician/	4 Pregnant at time of death 5	Other (Specify)		
BO) he death	Į,	a Oliviowii	the underlying saves siven in Bort I	23e. Did tobacco use contribute	to the cause of death?
ires that the signed by		Part II. Other significant conditions contributing to death but not resulting in Diabetes Mellitus	The underlying cause given in Fait i.	1 Yes 2 No 3 P	-
rds, I requires been sig hould be	Completed by	Diabetes Meintus		.   24a. Was an   24b. Were	autopsy findings available
Records, The law require	흹				to completion of cause of
Rec The I	5			1 Yes 2 No 1	Yes 2 No
Vital Rec ysician: The his certificate director, page	B B	25. Was case referred to medical examiner? Hospital: A leasting to PR/Outs	26.Place of Death (Check atient 3 DOA Other, Nurs		4
F V. Physi or this	⊢:	1 ✓ Yes 2 No	atient 3 DOA Nurs ne of Injury 28c. Injury at Work?	ing Home 5 Residence 6 🗸 Ot 28d. Describe how injury occurred	ner: Scene
n of \ding Phy. h. After tl	ë	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Tin	1 Yes 2 No	250. Describe now injury describe	
Sior Attend r death ector: by the	cati	2 Accident Investigation 28e Place of Injury - At home farm		28f. Location (Street and Number or	Rural Route Number, City
Division of Vital last or Attending Physician. Is after death.  al Director: After this certiled in by the funeral director.	ertification:	3 Suicide 6 Could not be determined (Specify)	,,,	or Town, State)	
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	O	29a. Certifier  (Check pply 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, ar	nd due to the cause(s) and manner as s	tated.
o the lithin 2 of the language.	Medical	one) 2 Medical Examiner: On the basis of examination and/or inve	estigation, in my opinion, death occurred	at the time, date and place, and due to	the cause(s)
F.3 F. 8	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (	Month, Day, Year)
		Samet Routhall. MU	O.C.M.E.	August 20, 20	08
H		30. Name and actress of person who completed cause of death (Item 23a)			
* \		Pamela E. Southall, MD Assistant Medical Examiner	111 Penn Street, Baltimore,	MD 21201	
9	tate	31. Date filed (Month Day, Year) 2008	20 199-		

DHMH 17 Rev 1/2001 OCME 2006

**ORIGINAL** 

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician /Medical Delaney 2:03 AM lommie August 2008 4b. City, Town, or Location of Death 4c. County of Deatl 4a. Facility Name (If not institution, give street and number) Examiner n/a The Johns Hopkins Hospital **Baltimore City**  Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 219-38-1878 Yrs 68 **Director** 3/7/1940 West Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland or 28a-f show e notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Director Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō other traumatic event, the Medical Examiner must be 7882 Tall Pines Court items 23a Apt. C 21061 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 9 If Yes, Give Year or Dates: Specify White 2 3 Widowed 4 □ Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Telephone Elementary/Secondary (0-12) nd Mental Hygiene. marked other than College (1-4 or 5+) Communications 12 Operation Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill ment of Health and Mental Hitant: If item 27 is marked oth Be Thomas M. Delaney Rita B. Weisenmiller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Rita L. Delaney / Sister 419 Walton Avenue Baltimore, <u>Maryland</u> 21225 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Bayview Crematory Baltimore, Maryland 8/27/2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, MD Mark T. 21229 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis **Physician** disease or condition resulting in death) /Medical Examiner Myslodyslastic Syndrome Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or es a conse juince of) K puer the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician P.O. Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Tectopic pregnancy ģ in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. \$ page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate has 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 \sum Nursing Home 1 ☐ Yes 2 No 3 🗆 DOA 2 ER/Outpatient 5 Residence 6 Other (Specify) ၉ within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury or Attending 1 🗌 Yes 2 🗆 No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 Res 000

DHMH 17 Rev 1/2001

16

State Registrar Rohan R.
31. Date filed (Month, Day, Year)

ORIGINAL

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

32. Rogistrar's Signature

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death H 2008 Month **Physician** Louis Jacob Doetsch, Sr. 5.57P M August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FSURNIE ANNE BAISIMORE WASHINGTON MEDICAL CENTER Con ARUNIDE If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 X M 2 □ F 219-07-3412 92 Director Dec 25, Maryland 1915 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at Director Maryland Anne Arundel Pasadena 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8631 Fort Smallwood Road 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WW 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. "natural", or iten dical Examiner Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: 3 X Widowed 4 ☐ Divorced White other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Pasadena Yacht Yard 12 Owner | 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dr. Ernest P. Doetsch Elizabeth P. Cottle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any Injury or other traoonce. Louis Jacob Doetsch, Jr. (Son) 311 Winchester Road, Grasonville, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery: 8/26/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Europe Servin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Rd., Pasadena, Md. 21122 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner THEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the bunal-transi that initiated events resulting in death) Last Due to for as a nonsequence of P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, by 1 Yes 2 No 3 Probably 4 nknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an perform 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b Time of 28d. Describe how injury occurred After 5 Pending investigation spital or Attendil ours after death. neral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral L Hospital 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 15+1 30. Hame and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month.

Hos 3 Registrar's Sign

2008

Glen Burne ms 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Cartificate of Death Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) AUGUST 2008 9:06P **ESTELLE ETELSON** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE BALTIMORE 2 SPRINGBRIAR LANE Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Min. 219-36-0396 1 ☐ M 2 🗓 F 12/28/1914 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐Yes 2 No BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21208 USA 2 SPRINGBRIAR LANE 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Specify: WHITE Specify: 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) RETAIL Elementary/Secondary (0-12) 12 College (1-4or 5+) **PROPRIETOR** LUMBER & HARDWARE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOWN **EMANUEL** GORDON FANNIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 238 DAN TROY DRIVE, WILLIAMSVILLE, NY ELLEN BERNSTEIN / DAUGHTER Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE, MD BETH TFILOH 08/22/2008 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 

Ectopic pregnancy Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗆 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐Yes 2 ☐No 26. Place of Death (Check only one)

**Physician** /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

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**Funeral** 

Director

show

ed other than "natural", or items 23a or 28a-f shorevent, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examina

Baltimore, Maryland 21215-0036

death with the Maryland

Examine burial-trai attending physician for use as the buria use as signed by the a certificate has been s rector, page 2 should To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director;

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician/Medical ģ Completed Be

Medical Certification: To

25. Was case referred to medical examiner? 1 Yes 2 No 27. Mann Death

3 Suicide 4 ☐ Homicide 29a, Certifier

29b. Signature and title of

2 Accident

5 Pending investigation 6 Could not be

determined

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

Example 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 1)27569 8120/08 38 Greene Tree Rel =

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address

31. Date filed (Month, Day, Year) **AUG 2 5** 

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State

Registrar

10

State of Maryland / Department of Health and Mental Hygien [ ] [] Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Haze1 Edwards August 18 2008 AM 10:11 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oxon Hill Prince Georges 103 Mel Mara Dr. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | 1936 | 9. Birthplace (State or Foreign (Month, Day, Year) | North Carolina 5. Social Security Number 7. Age (In vrs. last birthday) 1 ☐ M 2 反 F 72 February North Carolina 577-54-2491 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No MD Oxon Hill Prince Georges Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20745 103 Mel Mara Dr. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. ☐ Yes 2 No 1 Yes, Give 1 Never Married 2 Married **Black** 1 ☐ Yes 2 No Specify: Specify: ģ 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private 12th Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robinson Julius Lester Sturdivant Ethe1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Edwards/Daughter 103 Mel Mara Dr., Oxon Hill, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \*4 ☐ Donation 5 ☐ Other (Specify) 8/23/2008 Lincoln Cemetery Suitland, Maryland 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy St. NW, Washington, DC 23a. Part1 Enter the disease, or complical insith if caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shows, or heart failure. List only one in use in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimers Disease disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗀 No 2X No 1 Tyes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home SX Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🛣 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dev. Year) MD duparasane 8/21/2008 D16619 30. Name an laddless of person who completed cause of death (Item 23a) (Type, Print) C. Vergara-Soares 9940 Franklin square Dr., White Marsh, MD 21236

3

Registrar

State

**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28e-f show treumatic event, the Medical Examinar must be notified at

Hygiene. filed within

Health and Mental Hygie tem 27 is marked other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other treumatic event 2008.

Physician

/Medical

Examiner

use as the burial-tran

the attending physician and

s been signed by the should be detach

has been

certificate

this funeral

After

filled in by the Director:

death.

within 24 hours a

Attending Physiclen:

page 2

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

with the Maryland

death v

72 hours after

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) AUG 2 5 2008 32 Registrar's Signature

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2008 pencer 4b. City, Town, or Location of Death 4c. County of De Name (If not institution, give street and number) more If Under 1 Year 9. Birthplace (State or Foreign 8. Date of Birth Month, Day, Year), 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours Min 212-48-2450 Usual Residence of Decedent 11XM 2□ F Yrs. lano 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Yes 2 No more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify If Yes, Give Year or Dates: 3 ☐ Widowed 4 🂢 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Durial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemeter 22. Name and Address of Facility 21. Signature of Funeral Service Licenses W. North tuneral Home Joseph Ave. Balto Md. 222 23a. Perfl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Desade Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): PISEON Diabele 23b. Did tobacco use contributa to tha cause of death? Part II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yea 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Tyes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

**Physician** /Medical Examiner or Attending Physician: The law requires that the daath cartificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

Items 23a

"natural", or

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Department of Heelth end Mentel Hygie Important: If Itam 27 is marked other any injury or other traumatic event, it

other traumatic event, the Medical Examiner nust be notified at

Completed by Funeral Director

Be

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760.

Completed by Physician/Medical Examiner To the Hospital or Atlending Physician: The law requires that the daath within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attar completely filled in by the funeral director, page 2 should be detached for a Medical Certification: To Be

27. Manner of Death 1 Natural

2 ☐ Accident

3 ☐ Suicide

4 \ Homicide

29b. Signature and title of certifier

5 ☐ Pending

investigation

6 Could not be determined

28d. Describe how injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year)

29c. License number

D 31464

28b. Time of

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ST Suite 301 BALTIMOREMN 2/201

Registrar

SHOALIZ A. HAPKIMI MD N. ENTAW 221 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 25

28a. Date of Injury (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 422 pM CSAC. 200 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, pr. Location of Death 4c. County of Deat Examiner HIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09 -24 -19 If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days 215-32-7678 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No 141 1 1mg **Funeral Director** 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country . Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 Married 1 Never Married 1 ☐ Yes 2 No Specify: Completed by Black 3 ☐ Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If flem 27 is marked other tran "na any Injury or other traumatic event in the page." (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SUDERVISOR 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SIDOA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2908 Chelsa 150 (TO tas Ku no a 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 ☐ Cremation 3 Removal from State MARILA 4 □ Donation 5 □ Other (Specify) lores 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Helt. BERT 120 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 200 3 Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 10 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2□ No 2 PR/Outpatient 3 DOA Yes 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of anner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 atural 2 Accident To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License numb 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie ause of death (Item 23a) (Type, Print) son who completed 30. Name nd address of per 31. Date filed (Month, AUG Registrar

Vatient Known is

Division or Vital Records, P.O. Box 68760, 本 or Attending Physician: The law requires that the death certificate be executed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 11:48 PM 2008 Anne M. Gearhart /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore St. Hones HOSPITAL n/a If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 ☐ M 2 ☐ XF Yrs. 78 **Director** 218–26–4636 07/26/1930 Baltimore, MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show r than "natural", or items 23a or 28a-f sho 1 ☐Yes 2 ☐ No Director N/A MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with 21229 United States 1026 Rock Hill Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental h Pages 1 and 2 should be Lester E. Edmonds Anna Linder 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trau Mr. Henry T. Gearhart (Spouse) 1026 Rock Hill Avenue, Baltimore, Maryland 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 08/21/2008 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Hubbard Funeral Home, Inc. Made 1. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disea a complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician a Physician/Medical attending p for use as t P.O. Box IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day signed by the a d be detached fo 5 Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 3 Probably 4 □ Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 🗷 No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∏Yes 2 3 No 1 Impatient 2 ER/Outpatient 3 DOA Medical Certification: To this Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 | Pending Injury 1 ☐Yes 2 ☐ No investigation ours after death.

Neral Director: A
filled in by the fu death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 1921

32

Registrar's Signature

570

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Mary and Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year <u>5:0</u>3 P <sup>M</sup> Delores Gross
4a. Facility Name (If not institution, give street and number) AUGUST 20, 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE IVY HALL GERIATRIC REHAB MIDDLE RIVER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. 10/03/1921 86 87 212-26-1726 Director LOUISIANA Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov ury or other traumatic event, it a Medical Exprisitival by notified at BALTIMORE MD 1 XYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21217 1943 W. MOSHER STREET 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 □Yes **X**□No þ Specify. 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME HOUSEWIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **JOSEPH** CONWAY OLYMPIA FALGOUTE ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau DOLORES GARCIA/GRANDDAUGHTER 3783 GALDWAY DRIVE, SNELLVILLE, GA 30039 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE NATIONAL 08/26/2008 BALTIMORE, MD 4 Donation 5 DOther (Specify) 22. Name and Address of Facility James A. Morton & Sons F. H., In 21. Signature of Funeral Service Licensee torion 1701-31 Laurens St. Baltimore, MD 21217 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Domente Sequentially list conditions, if any, leading to immediate cause. Errer Underlying Cause (Disease or injury that initiated events Examine ending physician and use as the burial-transit Diseans Chrone hione resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery The law requires that the death 3 Ectopic pregnancy Month Yea Day 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 1 □ Yes 2 INO al or Attending Physician: "s after death.
Il Director: After this certifica of in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🖳 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide within 24 hours a To the Funeral D Hospital 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D31464 mo 08

Registrar
DHMH 17 Rev 1/2001

N. ENTHW ST finite 300 BALTIMORE MD 2121

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAS HAM 1

A

31. Date filed MUG Day, 3 3 2008

821

32. Registrar's Signature

Physician /Medical **Examiner** 

**Physician** 

/Medical

Examiner

**Funeral** 

Director

iral", or Items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once.

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

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death with the Maryland

Examiner

Physician/Medical

Completed by

Be

Certification: To

Attending Physician: The law requires that the death certificate be executed as the burial-transit and attending physician s been signed by the should be detached page 2 After this certificate funeral director, ours after death.
neral Director: A
filled in by the fu ō

Division or Vital Records, P.O. Box 68760,

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 1 Yes 2 No 27. Manner of Death (Month, Day Year) 1 X Natural 5 Pending 1 TYes 2 □ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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within 24 hours a

To the Funeral I

Saima Khawaja, M.D. 31. Date filed (Month, Day, Year) State AUG 2 5 2008

29b. Signature and title of certifier

Soume

1801 Wentworth 32 egistrar's Signature

Khow

30. Name and address of person who completed cause of death (flem 23a) (Type, Print)

100

DHMH 17 Rev 1/2001

29c. License number

D0058965

Baltimore, MD

29d. Date signed (Month, Day, Year)

August 21, 2008

21093

		4	ForState	State of M		/ Depa		of He	ealth a		ntal Hyg	iene	008	2717	6
100	- P		Registrar  1. Decedent's Name (First, Middle, L.	361)		061	incate	UI L	Calli	2.	Date of Dea	eg. No:	000	3. Time of Dea	th
п	Physici	an									Month	Day	Year	7:33 pm	
1	/Medic		Frank J. G 4a. Facility Name (If not institution, gi				4b. City, To	own or l	ocation of	f Death	indriz		ounty of Death		
	Examin	er	0 1 /	1 1	1	1	2 1	1.		_		N	1 6	,	
	Francis		5. Social Security Number 6.	tan Hos	e (In yrs. last	birthday)	If Under 1		If Under 2	24 Hrs. 8.	Date of Birth	1	1	iplace (State or Foi	eign
	Funeral Director		219-01-9209	1 <b>X</b> M 2□F	88	Yrs.	Months	Days	Hours	Min.	(Month, Day av 20.	1920	Mary	yland	J
	· · · · · · · · · · · · · · · · · · ·		Usual Residence of Decedent								<u>a</u> ,,	1320			
	how		10a. State 10b. County		10c. City, T	own or Lo	cation							10d. fnside City Li	
	Ba-f-	cto	Maryland N/A			Balti	more							1 Yes 2	NO
	ith th or 28	Director	10e. Street and Number				10f. Zip 0	Code		_	1	-	of What Cou		
	23a	ral	10 N. Calvert S						2120				ited S		
	be filed within 72 hours after death with the Maryland tall hygiene. id other than "natural", or items 23a or 28a-f show event, the Medical Exeminal must be indiffed at	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	?	13. \	Vas Decede f Yes, specif	ent of His by Cuban	panic Orig , Mexican	gin? (Specif , Puerto Ric	y Yes or No- an, etc.)	14.	Race - Amer Black, White		
36	s afte	by Fi	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Y Yes 2 ☐ If Yes, Give Year or Dates:	NO WWII		I□Yes 2	No 🗘	Specify:			Sp	pecify: W	hite	
21215-0036	hour	ed t	15. Decedent's I			6a. Deced	lent's Usual	Occupa	tion			16b. Kind	of Business/I	ndustry	
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212	iene.	E O	Elementary/Secondary (0-12)	Colfege (1-4or	5+)		Farm	Work	er			Agr	icultu	re	
b	Hygin other	BeC	17. Father's Name (First, Middle, Las	t)	· · · · · · · · · · · · · · · · · · ·				18. Mothe	r's Name (F	irst, Middle,	Maiden Su	mame)		
lar	Mental Merked o arked o	To B	Frank F. Gilk						Α	nna i	M. Sc	hwelt	zer		
Maryland	2 should be filed and Mental Hygie is marked other is aumatic event, it		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	g Address (	Street a					own, State, Z	ip Code)	
	12 g g		Mr. Paul E. Gilka	/ Cousin	NAME AND ADDRESS OF THE OWNER, THE PARTY OF		Rush		d J		tsvill	e, MD	2108	34	
Baltimore,			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	□ Pamoval from State		e of Dispo etery, cren	sition (Name natory or oth	e of ner place	)	Date			tion - City or 1		
<u>Ĕ</u>	Pa 7 II:		4 ☐ Donation 5 ☐ Other (Spec	eity)	Holy		eemer	Cem.		ug. 23	3,2008		timore		
at	permit. Pa Departmer Important any injury once.		21. Signature of Funeral Service Lic	Michael	E. Canap		. Name and							rd Road	0
=	ă∆ <u>⊆</u> ≅ ∂		M. C.C.	-9-1.						ck, Ir			imore,		4
и			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause y one cause on each l	d the death. I	Do not ent	er the mode	of dying	, such as	cardiac or re	espiratory ari	rest,		Approximate Interval Betweek Onset and Deat	1 h
	Physician		Immediate Cause (Finaf disease or condition	- a Hyliano	scler	ote	Cler	velu	e Vacs	cula	1 /2	Sea 2	e	year	5
1	/Medical Examiner		resulting in death)	Due to (or as	a consequer	nce of):	-							11	
		-	Sequentially list conditions,	b. Due to /or as	a consequer	yen	sion						-	year	5
V	ted nslt	nlu	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 41	2 001.304201	100 01).									
1	be executed iicien and burial-translt	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequer	nce of):									
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89	leath certificate t ettending physi I for use as the b			J											
Вох	h cer endin	N/N	IF FEMALE: 23b. Was decedent pregpant	23c. If yes, outcome 1□Live birth	e of pregnanc		Ectopic pre	doaner.				230	d. Date of deli	•	
	ne deat the ett hed for	SICIA	in the past 12 months?	4☐ Pregnant a	_		Other (spe						Month	Day Year	
P.O.	that the do	Physician/Medi	9 ☐ Unknown												
	ires that signed b d be det	by	Part fl. Other significant conditions	contributing to death	but not resulti	ng in the u	nderlying ca	use give	n in Part I.					the cause of death	
Records,	w requir been si should										101	/es 2 □ I	No 3□Pro	obably 4 Donkr	iown
ecc	law r as be 2 sh	Completed									24a. Was autop	sy	24b. Were au	topsy findings avai	lable e of
<u> </u>		20 LO									perfo	rmed? 2 No	death? 1 ☐ Yes	2 No	
of Vital	Physician: The law this certificate has be ral director, page 2 s	Be (	25. Was case referred to medical examiner?							of Death (	Check only o	ne)			
) t	hysi this c	2	1 ☐ Yes 2 ☐ No	Hospital: 1 Infopat			nt 3 DO		4 🗀 140				Other (Spec	cify)	
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Sio	Attendir death. ctor: Al y the fu	cat	2 Accident investigat 3 Suicide 6 Could not	he		- 6	М		/es 2 🗆		f Location /	Ptroot and i	Number or D	ural Route Number	
Division	or Al	Certification;	4 Homicide determine	28e. Place of it	njury - At nome etc. <i>(Specify)</i>	e, rarm, sti	reet, factory,	office		20	City or Tov		VUITIDE/ OF AL	Irai Houte Number	
	To the Hospital or Attending Ph within 24 hours effor death. To the Funeral Director: After thi completely filled in by the funeral		29a. Certifier 1 Certifying	Physicien: To the bes	t of my knowle	edge deat	h occurred a	at the tim	o date an	nd place, an	d due to the	Called(e) as	nd manner as	stated	
	24 hc 24 hc Fun etely	edical	(Check only 2 Medical Ex	aminer: On the basis and manner s	of examination	n and/or in	vestigation,	in my op	inion, dea	th occurred	at the time,	date and p	lace, and due	to the cause(s)	
	ithin o the ompl	Me	29b. Signature and title of certifier	1-			29c.	License	number				signed (Monta		
	F > F 0		> BULLIAM!	the_			Design of the second	IJ3	854	-3		iAugo	15/2	2,200	8
	1		30. Name and address of person	mpleted cause of	death (Item 2	3a) (Type,	Print) -					. ,		<u> </u>	
	り		KOWN H See	tunes in	37el	1 6	ich K	aver	Bus	levier	(B	ltin	were,	2, ser Marylun	d
	St	ate	31. Date filed (Month, Day, Year) AUG 2 5 2	32 Regis	trar's Signatur	re								1	
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						ORIGI	NAL								

			1 - For Amend 19a, por Registrar  1. Decedent's Name (First, Middle, La			\				2. Date of D		Year	3. Time of Death
0	Physici /Medic		Albert G. Greaver							8	24	08	5:45 AM
5	Examir	er	4a. Facility Name (If not institution, gir		ber)				Location of Dea	ith	4c. Co	ounty of Death	
7	Funanti	*	Good Samaritan Hos 5. Social Security Number 6.		. Age (In yrs. la	st birthday)	If Under	timo	CE If Under 24 Hi	s. 8. Date of B	rth	N/A 9. Birth	place (State or Foreign
00	Funeral Director	g:		1 <b>⊠</b> M 2□F	89	Yrs.	Months	Days	Hours Mi	s. 8. Date of Bi (Month, D July 29	, 1919	Mar	yland
25	and		Usual Residence of Decedent  10a, State 10b, County		10c. City,	Town or Lo	cation						10d. Inside City Limits
120	within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28a-f ehow the Modical Examities must be notified at	tor	Maryland Baltim	ore	Bal	timore							1 ☐ Yes 2 🔀 No
MY	th the	Funeral Director	10e. Street and Number				10f. Zip	Code			10g. Citize	n of What Cou	intry?
208	ath wi	rai	3123 Harview Avenue	· · · · · · · · · · · · · · · · · · ·				2123			US		
S 6	er de	nne	11. Marital Status	Armed For		. 13. V	Vas Deced Yes, spec	dent of H orfy Cuba	ispanic Origin? In, Mexican, Pu	Specify Yes or N rto Rican, etc.)	0- 14	Race - Amer Black, White	
036	urs aft	by F	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 🔀 Yes : If Yes, Give Year or Da	)	1	☐ Yes	2[ <b>X</b> No	Specify:		S	pecify: Wh	ite
S-0-5	72 ho	Completed by	15. Decedent's E (Specify only highest gr	ducation		16a. Deced	ent's Usua kind of wo	al Occup	ation during most of w	orkina	16b. Kind	of Business/I	ndustry
7/6	ne. hen	mpie	Elementary/Secondary (0-12)	College (1-	4or 5+)	Roo	OO NOT us	se retired	1)		Roof	ina	
A 50	filed v Hygie other t	ပိ	17. Father's Name (First, Middle, Las	1)		NOO	10		18. Mother's N	ame (First, Middle		<u> </u>	
GREAVERryland 21215-0	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Me	To Be	Frederick Greaver	,					Irene L	ochner			
GREAVER S Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. It was 12 in marked other then "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examinal must be notified at	0	19a. Informant's Name/Relationship Lucille Lochner / Wi	(Type, Print) Fe		19b. Mailin	g Address 23 Har	(Street	and Number or I	Rural Route Numi altimore N	ber, City or T Maryland	own, State, Z 21234	ip Code)
RT.	s 1 an f Heal Item 2 other		20a. Method of Disposition		20b. Pla	ace of Dispos metery, crem	sition (Nan	ne of	1 1	Date	20c. Loca	tion - City or	own, State
3e imo	Page: nent o ant: If		1 X Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Speci			rkwood (			8/	27/08	Baltin	nore Mart	/land
ALBERT Baltimore,	permit. Pages 1 and 2 Depertment of Health a Important: If Itam 27 to eny Injury or other tra <u>2005</u> 8.		21. Signature of Funeral Service Lice	nsee Ve Of		12 5	eonard 305 Ha	d Jodra	NUCK, The I Road Ba	ltimore Ma	aryland	21214	
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8760,	death certificate be executed a strength of a strength of for use as the burial-transit	dical		d									
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0	at the d by the stached	hys	9 Unknown	9□ Unkno	wn								-
<u>8</u>	ires tha signed d be del	by §	Part II. Other significant conditions	_				•			tobacco use Yes 2 🗆		the cause of death?
oro	w requires been sign should be	eted	DM, HYPE ANEMTA	1116/03	i ch	134/1	DIEN		ANCER	N 550 E 1			-
	has l	ם	- HIVE/UIT							24a. Wa aut	s an opsy formed?	prior to death?	topsy findings available ompletion of cause of
Rec	£ 000	Ē										1 L Yes	2 No
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f Vital Rec	ysician: The	Be	25. Was case referred to medical examiner? 1 □ Yes 3 No	Hospital:	patient 2□E	R/Outpatien	t 3 🗆 DC	Oth	or.		опе)		ufy)
n of Vital Rec	rig Physician: The law requires that the death certifica if fer this certificete has been signed by the attending ph uneral director, page 2 should be detached for use as th	Be	examiner? 1 Yes 2 No 27 Manner of Death	28a. Date o		R/Outpatien 28b. Time of Injury	2	8c. Injur Wor	er: 4 □ Nursing y at k?	1 ☐ Yes eath (Check only	one)	□Other (Spec	ify)
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Division of Vital Records, P.O. Box 68	i or Attending Physician: Thater death. Director: After this certificate	Be	examiner?  1 Yes 7 No  27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	28a. Date o (Monti	f Injury 2	28b. Time of Injury	M 2	28c. Injur Wor 1 🗆	er: 4 □ Nursing y at k?	ath (Check only Home 5 Re 28d. Describe	one) sidence 6 how injury	□Other (Spec	ral Route Number,
Division of Vital Rec	Hospital or Attending Physician: The 4 hours after death. Funaral Director: After this certificete tely filled in by the funeral director, pag	Certification; To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Matural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only)  2 Medical Examiner  1 Yes 5 Pending investigative 6 Could not independent	28a. Date o (Mont/	f Injury o, Day Year)  of Injury - At hom g, etc. (Specify)	28b. Time of Injury	M 2 M eet, factory	28c. Injur Wor 1	er: 4 □ Nursing y at k? Yes 2 □ No	1  Yes eath (Check only Home 5  Re. 28d. Describe 28f. Location City or T	sidence 6 how injury  (Street and own, State)	Other (Specocured	ral Route Number,
Division of Vital Rec	o the Hospital or Attending Physician: The inhin 24 hours after death. of the Funeral Director: After this certificate completely filled in by the funeral director, pag	Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigative 3 Suicide 6 Could not determined  29a. Certifier Certifying P	28a. Date o (Month	f Injury o, Day Year)  of Injury - At hom g, etc. (Specify)	28b. Time of Injury	M 2  eet, factory	RBc. Injur Wor 1 /, office	er: 4 □ Nursing y at k? Yes 2 □ No	1  Yes eath (Check only Home 5  Re. 28d. Describe 28f. Location City or T	sidence 6 a how injury  (Street and own, State)	Other (Specocured	ral Route Number,
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Division of Vital Rec	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate completely filled in by the funeral director, pag	edical Certification; To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Matural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier  20b. Name and address of person who	28a. Date of (Month) 28e. Place buildin miner: On the ba and mann	of Injury - At homog, etc. (Specify)  Lead of my know sis of examination stated.	28b. Time of Injury  ne, farm, stre  on and/or inv  23a) (Type,	M Print)	28c. Injur Wor 1 , office	er: 4 Nursing y at k? Yes 2 No  ne data and pla pinion, death oc e number	1  Yes eath (Check only Home 5 Re 28d. Describe 28f. Location City or T	(Street and own, State)  c house(s) a date and p	Other (Specocured  Number or Ru  at manner as lace, and due signed (Monti)	ral Route Number,  stated to the cause(s) n, Day, Year)
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Aug 22<sup>Day</sup> 2008 ear Physician P 10 John Stanley Goodwin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll Westminster Carroll Hospital Center Date of Birth (Month, Day, )

Jan 10, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, , 1940 MD **Funeral** Sex M 2□F Hours Days 68 212-38-1454 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ms 23a or 28a-f show must be notified at 1 Tyes 2 No Director Winfield MD Carroll 10a. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21784 1201 W. Liberty Rd. Funeral ural", or Items 2 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 Pves 2 No 1962- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married Ž Married White 1 □ Yes 2 No Specify: Specify 1965 þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natun any Injury or other traumatic event, the Medical once." 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Joseph Gartland Plumbing Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be C. Marie Fleming Harold Goodwin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1201 W. Liberty Rd. Winfield, MD 21784 Lois Goodwin (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/27/2008 Winfield, MD Ebenezer Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Furrier-Queen Funeral Home and Crematory, 1212 W. Old Liberty Rd. Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2000No Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: Hospital: 1 ☐ Yes 2 No 1 🗌 Inpatient 2 XER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) Injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, in by the funeral s after death.

Baltimore, Maryland 21215-0036

within 24 hours a To the Funeral I

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie

ause of death (Item 23a) (Type, Print)

MD 6190 Gener town alva Eldersbus, MD77

Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29a. Certifier

31. Date filed (Month, Day, AUG 2

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Patricia 1125 PM Hall 8 20 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore FRANKLIN Square Hospital Center Rosedale 8. Date of Birth Month, Day Year July 12, 1938 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 □ F 70 New York Director 055-32-7081 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exemples. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County MD. Baltimore 1 ☐ Yes 2 ☑ No Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3101 Four Seasons Court Apt. B3 21222 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White ģ 3 ☐ Widowed 4X Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaraunt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Pietkewvikz ပ္ Mary Ligiecki 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ben Hall Son 321 Ligar Loop, Havre DeGrace, MD. 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition August 22, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore City, MD. Bayview Crematory 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, MD. 21222 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as consequence of): cell metastatic Cancer /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ned by the a P.O. I 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 31. Date filed (Month, Day, Year) AUG 25 2008

29b. Signature and title of certifier

30. Name and address

Binh



and manner stated.

person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

md

Balto

DR.

21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical APT 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 42 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 1**X**M 2□ F Hours 219-40-09 Months Days Director 08/0 MASU Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f shov injury or other traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Completed by Funeral Director T MORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 dow EVERE AV2 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" amortant: other traumatic events and ponce. 5.A. 21215 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) DISAbleD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PRACE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DISTER <u>uB</u> DALTO, MO 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 122/0 METRO CREMETOR BALTO 22. Name and Address of Facility 1-10 well 0 21. Signature of Funeral Service Licenses Filmeral towle 4600 UBERM Hots 130100 MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** INFARCTION 1-10000 MYOCHESDING /Medical Due to (or as a consequence of): **Examiner** D135 0182 -COCWNBOU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month . □Yes 2√No 9 □ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ C ZD ZRIVIK 3017 1 Yes 2 No 3 Probably 4 Unknown Completed O eccusion 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate I 1 ☐ Yes 2 ☐ No 1 □Yes 2/2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No\_ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 182 Natural 2 Accident 28b. Time of 28c. Injury at Work? MU 5 Pending investigation NILA 1 ☐ Yes 2 ☐ No NUV Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide N within 24 hours a

To the Funeral C 29a. Certifier 🖎 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatore and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARDISON BUN. 2300

Registrar DHMH 17 Rev 1/2001

State

10 HOTOND

2008

31. Date filed (Month, Day, Year) AUG 2 5

Registrar's Sign

Registrar

Mallika.

MALLIKA ANGITIPALLI,

31. Date filed (Month, Day, Year) AUG 2 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

HIGHSMITH

ST ALINES HOSPITAL

P22257

AUG 16th 2008

, 900 S. CATON AVENUE BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 23:19pM August 20, Evelyn Harvey /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince Georges Community Hospital Prince Georges Chever1v 8. Date of Birth (Month, Day, Year) 11–10–1940 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 😾 F 67 579-52-9553 Director Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be notifiled at 10a State 10c. City. Town or Location 10d. Inside City Limits 10b. County MD Prince Georges Capitol Heights 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 USA 7113 Giddings Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black ò 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Private Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jones Thomas Wayne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trau Michelyn Harvey/ Daughter 3207 Prince Ranier Pl., Forestville, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 8/30/2008 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Funeral Service Licensee 20011 716 Kennedy St. NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAC ARRTHYMIA FATAL **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed physician and s the burial-transif Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending phy IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2X No Month Day 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OBSTRUCTIVE PULMINARY 1 Yes 2 No 3 Probably 4 1 Unknown OF 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate har irector, page 2 performe 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2☐ER/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2 No 1 Inpatient ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No within 24 hours after death.

To the Funeral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 🔀 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

GARY

31. Date filed (Month, Day, Year)

HOSPITAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LITTLE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** HARRY CECILA 23 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sign HOSPITAL BALTIMONE NORTHWEST -ANDALLS TO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/08/1950 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. Guyana Director 220-06-2456 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show the Medical Expiritnet is ust be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or Items 23a 21221 U.S.A. 826 N. Woodlynn Road Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2XXVo Completed by If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced East Indian 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Janac Mohan Daniel Harry ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 539 Woodlyn Terrace, Essex, Maryland 21221 Debbie Rajcoomar (Sister) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 12 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. 08/26/2008 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. Maryland 21221 1407 Old Eastern Avenue, Essex, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of the failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STAGE KENM DESEME **Physician** END /Medical Due to (or as a consequence of): Examiner ASCITE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00066357 AVE 23 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1CEDDIVARI NORTHWEST HUSPITAI VENKATA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 25 Registrar

**ORIGINAL** 

08-06465

Frederick Martin Hamer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 27184

		- For State tegistrar		C	ertificate	of Deatr	7				eg. No.		10 = 1	D
Physicia		1. Decedent's Name (First, Midd	le,Last)							Date of Dea Month	Day	Year	3. Time of 2250	
edical Exami	ner	Frederick Man	rtin Hame	er						August 23	3, 2008			
		4a. Facility Name (if not institution		umber)	The second	4b. City, To		ocation of	Death			nty of Deal		
		317 Grovethorn Road				Middle	e River			n libr		nore Co	-	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)		r 1 Year	If Under	_	8. Date of Bi	rth (MM/DD/Y	YYY) 9. B	irthplace (State	ate or Foreign
Director		213-64-7973	1X M 2 F	-	54	Yrs. Months	Days	Hours	Min.	10/19	/1953		rylan	i E
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any.		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation							.10d. Insid	e City Limits
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		317 Grovethorn	Road				2122			l				District
with the ns 23a	Funeral	11. Marital Status		cedent Ever in	1 U.S. 13.	Was Decede If Yes, specif	nt of Hisp	anic Origi Mexican	n? ( Spe Puerto R	cify Yes or N tican, etc.)		Race - Ame White, etc.	erican Indian	, васк,
leath r iten	٣١	1 Never Married 2 X N	Married 1 Yes	2 X No	,							1.7h -	+-	
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5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner	à a	15. Decedent's Education (Sp.	ecify only highest gra	ade completed	) 16a. Dece	dent's Usual g most of wor	Occupation	on (Give k	ind of wo	ork done	16b. Kind o	of Busines	s/Industry State	
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5-0036 lled within 72 hours Hygiene. I other than "natu	Completed	17. Father's Name (First, Middle	e, Last)				1	8.Mother's	s Name (	First, Middle	, Maiden Surr	name).		
215 be file ntal Hy rked o	ě	Frederick Mar	tin Hamer	. Sr.				Agnes	s Qu	inn				
, MD 21215-0036 tearl 2 should be filed within 72 hours after tearl 2 should be filed within 72 hours after tear 27 is marked other than "natural", of traumatic event, the Medical Examiner 2	To B	19a. Informant's Name/Relation			19b. Ma	iling Address	(Street	and Num	ber or Ru	ural Route N	ımber, City or	Town, Sta	ate, Zip Code	9)
MD d 2 sho lith and n 27 is		Thomas Hamer (	Brother)		814	2 Plea	sant	Plai	ins 1	Road,	Towson	, Mai	yland	21286
and and tealth		20a. Method of Disposition			b. Place of Dis	position (Na	me of cem	netery,		Date	20c. Loca	tion - City	or Town, Sta	te
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within pergent and 2 should be filed within progresser. I friem 27 is marked other it injury or other traumatte event, the Med		1 Burial 2 X Crematic	on 3 Removal	from State	crematory o Bayview	r other place		Tna	00/	2E /200	8 Dal+	imore	Mar	brefy
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Salt ermit epart npor jury		21. Signature of Funeral Service	ce Licensee>		Į.	1 407 C	Bru	zdzii	nskį	Funer	al Hom Essex	e, P.	A	21221
m 80 = 1		23a. Part I. Enter the disease, of			eth Donoton	tor the mode	of dving	such as c	ardiac or	respiratory a	rrest, shock,	or heart		imate Interval
Physician		failure List only one caus	e on each line										Betwe	en Onset and Death
\/ical xaminer	10 33	Immediate Cause (Final diseas		tic (m	orphine	) and	alco	hol	into	xicati	on			
Adminici		or condition resulting in death)	Due to (or as	a consequen	ce of):		•							
	L	Sequentially list conditions,	b		of):		_	_					-	
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	ធ	(Disease or injury that initiated events resulting in death) Last	Dun to (or or	a consequen	ce of):									
nted d ansit	ŭ	events resulting in security East				<u> </u>				188 =				
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8760, rtificate bo		23b. Was decedent pregnant in	Union Company	e birth	2	Fetal death	3	Ectopi	c pregna	ncy	Mo	onth	Day	Year
Sox 68 leath certi e attending for use as	cia	past 12 months?		gnant at time		Other (Sp	ecify)							
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of Vital Recling Physician: The later this certificate fineral director, page	<u>=</u>	27. Manner of Death	28a. Da (Mo	ate of Injury onth, Day, Year)	28b. 1im	e of Injury		ry at Wor						
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Division of Vital Records, tal or Attending Physician: The law requing a state death.  al Director: After this certificate has been siled in by the funeral director, page 2 should the lat in by the funeral director, page 2 should the death.	ertification:		ould not be	lace of Injury -	At home, farm	, street, facto	ry, office l	building, e	etc.	28f. Location	n (Street and n, State) $oldsymbol{31}$	7 Gr	vetho	e Number City
Division pital or Attent ours after death teral Director: filled in by the	l E	4 Homicide	etermined (Speci	fy) house						Middl	e Kive	r, m		
Fune fune ely fi	JO	29a Certifier	Physician: To the l	best of my kno	wledge, death	occurred at t	he time, d	ate and p	lace, and	due to the	ause(s) and i	manner as	stated.	(-)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buril.	.  <u>ខ</u>	one) 2 Medical E	xaminer: On the bas and manne	sis of examinat	tion and/or inve	stigation, in r	my opinio	n, death o	ccurred a	at the time, d	ate and place	, and due	to the cause	(S)
To To Con	Medical	29b. Signature and title of cert		S. States.		2	9c. Licen	se numbe	r		29d. Da	te signed	(Month, Day	,Year)
		(durots	2 '				O.C.	M.E.			Augu	st 24, 20	800	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ye ar **Physician** 9008 2ABET 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore- Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 215-40-4956 77 Germany May 6, 1931 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Director Maryland Arundel Anne Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 107 Magnolia Avenue 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes 2 Z If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Lauer Elizabeth Sommer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John F. Hayden (Husband) 107 Magnolia Avenue, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State Bayview Crematory 08-22-08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses McCully Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIOPULMONA ARREST Due to (or as a consequence of): FRONTOTEINFOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE Medical Certification: To

/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Division of Vital Records, P.O. Box 68760, attending physician for use as the buria certificate has been signed by the rector, page 2 should be detached within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

/Medical

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evarinat must be putilled any once.

Physician

Baltimore, Maryland 21215-0036

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yo 9 ☐ Unknown	1 Live birth 2 Feta 4 Pregnant at time of 6	al death 3 🗆 Ectopic	c pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	•	ulting in the underlying	g cause given in Part I.	1	se contribute to the cause of death?
COLITIS	DISORDE	R		24a. Was an autopsy performed? 1 □Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No
25. Was case referred to medical examiner? 1 ☐ es 2 ☐ No	Hospital: 1 ☐ Inpatient 2 🗷	ER/Outpatient 3 □	Other:	eath <i>(Check only one)</i> Home 5  Residence	6 ☐ Other (Specify)
27. Manner of Death  1 ★ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injur	y occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number, )
	yslcian: To the best of my kno niner: On the basis of examina and manner stated.				) and manner as stated. d place, and due to the cause(s)

29c. License number

51325

29d. Date signed (Month, Day, Year)

STE 108, PASABENA MD 2122

10

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8028 RITHIE MWY. BAMETHI MD

31. Date filed (Month, Day, Year) 2008 AUG 25

29b. Signature and title of certifier

🛣 Registrar's Signature

Baltimore, Maryland 21215-0036

P.O. Box 68760. nuer uns ceruncate has been signed funeral director, page 2 should be det Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** William January 19:41 2008 August 24, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Johns Hophins - Bayview Center Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days Months 1 □XM 2 □ F 212-28-8831 78 **Director** Maryland August 22, 1930 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, It e In Alfael Examination to notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 □Yes 21XNo Director Baltimore Dundalk Maryland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21222 7933 Stratman Road USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. XYes 2 Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🖁 No Specify. Specify: White <u>ک</u> 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7 years Furance Operator Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George January Anna Brooks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Ethel January wife 7933 Stratman Road, Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Druid Ridge Cemetery 20c. Location - City or Town, State 20a. Method of Disposition August 28. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State **2**008 Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Don't enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 06 disease or condition resulting in death) /Medical Due to **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be exec IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed? 2 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30./Name and address of person who completed cause of death om5 9106 911 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Month Year 2008 Martina Joyce Jones 4a. Facility Name (If not institution, give street end number) 4b. City, Jown, or Location of Death 4c. County of Death lare 8. Date of Birth (Month, Day, Year) 06/29/1952 5. Social Security Number . Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min. 1 □ M 2504F 220-60-7592 56 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland | Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4144 Cutty Sark Road 21220 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: 3 ☐ Widowed 4 🄀 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Elizabeth Conner Theodore Michael Weber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 Franklin Avenue, Baltimore, Maryland 21221 Charles Jones (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Inc 08/25/2008 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Ski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part T. Epier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 2 X No 25. Was case referred to medical examiner?

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Be Completed by

2

**Funeral** 

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evacinar must be notified at once.

Baltimore, Maryland 21215-00

To the Hospital or Attending Physician: The law requires that the death certificate be executed and physician

Examine burial-transit the for use as d be detach page 2 should funeral director,

Division of Vital Records, P.O. Box 68760,

Physician/Medical Be Completed by Medical Certification: To

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 🗆 Unknown

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 EN/Outpatient 3 DOA 28d. Describe how injury occurred

28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1 Yes 2 No

27. Manper of Death

1 Natural

3 Suicide

29a. Certifier

2 Accident

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Temil USITI

22817

30. Name an address of perso, who completed cause of death (Item 23a) (Type, Print) Mercedes

Frank

State Registrar

5 Pending investigation

6 ☐ Could not be

determined



this

death.

within 24 hours after deatl To the Funeral Director:

filled in by

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U U 8 1 - State Registrar Certificate of Death Req. No. 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 4/ M 2008 409051 /Medical 4b. City, Town, or Location of Death 4c. County of Deat **Examiner** 0 Date of Birth (Month, Day, Year) 11y 31,1920 oreian **Funeral** Days Hours 217-09-5701 88 Maryland July | Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show Department of Health and Mental Hygiens in a tree useau with the realyte Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examinational Demaithed at once. Maryland Anne Arundel Glen Burnie 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8094 Solley Road 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Schreier Catherine Augustav Williams ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) Patricia H. Joran Riverside Avenue, Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 08-27-08 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Brooklyn Park, Maryland 21. Signature of Funeral Service License McCully-Polyniak Funeral Home P.A. <u>3204 Mountain Road, Pasadena, Maryland 21122</u> rt1. Enter the disease, or compilerations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death rmmediate Cause (Final disease or condition resulting in death) **Physician** day NO /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ mon ia 1 Yes 2 No 3 Probably 4 onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes မ Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) harles 1/25 Q 31. Date filed (Month, Day, Year) State 2008 AUG 25 Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** MARGUERITE E. LANCIONE AUGUST 3:30 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** GOLDEN LIVING CENTER WESTMINSTER CARROLL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2X F Months Days Hours Min. Director 218-52-1797 96 7/4/1912 MARYLAND Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No 28a-f **ADAMS** PA LITTLESTOWN death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 650 SELLS STATION ROAD 23a 17340 USA Funeral or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify ģ Specify: 3 XWidowed 4 ☐ Divorced 'naturai", WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than ementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 9TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ RICHARD FORDYCE MARIE STEIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD C. FOWLER/SON 27 650 SELLS STATION RD. permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other ti LITTLESTOWN. PA altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 8/25/2008 BALTIMORE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ulle disease or condition resulting in death) /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit death certificate be executed Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown iis certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Division of Vital 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral c Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation Natural death. 2 Accident 1 ☐ Yes 2 ☐ No after death Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number 29b. Signa are and title of certifier 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) and address of person who completed cause Victory Street, Munchester, MD 21102 ohmby. MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 2:5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 10.32 An M Lewis Louise 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hophus Bayview Medicallenker Baltimore Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 1□M 2□F Months June 6, 1943 Maryland 65 <u> 214-38-3918</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ty⊡Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 United States 3225 Fairmount Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u> Malter</u> L. Ziolkowski Helen Krazemodenski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Nina Sauer (Niece) 214 N. Constitution Ave. New Freedom, Pa. 17349 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/25/2008 Towson, Maryland Hilltop Serv. Corp. 21. Signature of Juneral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part 1. Enter the sease or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filter. List only one cause on each line. Approximate Interval Between Onset and Death cardiovascular Immediate Cause (Final disease or condition resulting in death) collapse Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ED BY CENTRATION APPROV IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 1 ∐ Yes 2 🗹 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

/Medical Examiner sician and burial-trans law requires that the death certificate be exec Box 68760, attending p P.O. signed by the a Division of Vital Records, page 2 Physician: funeral director, After this or Attending 24 hours after death. Funeral Director: A filled in by the

Examiner Physician/Medical Completed Be Medical Certification: To completely

**Physician** 

/Medical

**Examiner** 

**Funeral** 

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?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examinar must be notified at

1 and 2 should be filed within 72 hours after death with 'Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or

permit. Pages 1
Department of H
Important: If iter
any Injury or ott

**Physician** 

Baltimore, Maryland 21215-0036

28a. Date of Injury (Month, Day, Year) Injury 124 AM 1 Natural 5 Pending investigation Subject involved in house for a 1(Hio8) 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Bural Route Number, City or Town, State) 3225 Fermount Ave 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Momicide residence Beltimore, Maryland 21224 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

To the Hospital o within 24 hours af To the Funeral Di

Registrar

Saptanshi Johns Hophus, shas 31. Date filed (Month, Day, Year) 32.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

egistrar's Signature

29c. License number

AF 2664200.

4940 Eastein Av. Ballimox, MD

Avenue

			For State Registrar	State of Maryla		irtment of H rtificate of L		Mental Hygie Reg.		
	3 78	-9	1. Decedent's Name (First, Middle, Las					2. Date of Death		3. Time of Death
	Physici /Medic		James Louis	Miller				08	Day Year 2008	7:14 AM
)	Examin	er	4a. Facility Name (If not institution, give Baltimore VA	e street and number) Medical Cen	ter	4b. City, Town, or		h	4c. County of Death	
			5. Social Security Number 6. S		s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	0 Birth	place (State or Foreign
	Funeral Director		1	<b>X</b> M 2□ F	Yrs.	Months Days	Hours Min.	(Month, Day, Ye		ntry)
- 19 - 10 - 10	The station		212-32-5492 Usual Residence of Decedent	/]				APRIL 17,	1937	MD
	ylanc low		10a. State 10b. County	10c. 0	City, Town or Lo	cation				10d. Inside City Limits
	Mar fled	ţċ	MD	BA	LTIMORE					1 XYes 2 No
	r 28g	Director	10e. Street and Number		<b>D1</b> 11 101 <b>L</b>	10f. Zip Code		10g.	. Citizen of What Cou	ntry?
	h wit		5200 BOWLEY'S LA	_ APT #103		21206			USA	
	ems ems	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-	14. Race - Ameri Black, White,	
٥	after or ite		1 ☐ Never Married 2X Married	1 X Yes 2 No If Yes, Give		i∏Yes 2⊠No	Specify:	10 7 10 011, 010.)	Specify: BLA	
215-0036	within 72 hours after death with the Maryland ene. than "natural" or items 23a or 28a-f show the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						
بر م	be filed within 72 he stal Hygiene. ed other than "natu event, the Medical	Completed	15. Decedent's Ed (Specify only highest gra	lucation ide completed)	(Give	fent's Usual Occupa kind of work done o DO NOT use retired	during most of war	rking   16l	b. Kind of Business/Ir	dustry
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	should and Men s marke umatic	은	MILTON MILLER  19a. Informant's Name/Relationship (	Type Print)	19h Mailir	nn Address (Street	ELSIE	WILSON	ity or Town State 7	NDALLSTOWN,
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	s 1 an of Heal Item 2		ZINA A. HIGGS  20a. Method of Disposition	20b	. Place of Dispo	sition (Name of	1	IR APT.	#203, MD c. Location - City or T	
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gaitimore,	artme ortani injury		4 ☐ Donation 5 ☐ Other (Specifical Seprice Licer		ARD:	ENT 2. Name and Addres	4.60	9/2008   HA		
g	permit. Pages Department of Important: If It any Injury or o		1/alana	Thank.			WE	SLEY CHAVI		
No.	10000		23a, Part1, Enter the dispass, or com	plications out caused the de	ath. Do not ent	er the mode of dvin	EASTERN  g. such as cardia	AVE., BALT	LIMORE, MD	21231 Approximate
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XOR	death certif e attending id for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy	,		23d. Date of deliv	-
	dea re att	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time o 9□Unknown		Other (specify)			Month	Day Year
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Ś	es th igned be de	by F	Part II. Other significant conditions of	-	-	nderlying cause give	en in Part I.	23e. Did tobac	cco use contribute to	
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	The ate ha	No.						performe	d?   death?	2 □ No
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0	iding Physician; th. : After this certifica funeral director, i	2	1 ☐ Yes 2 No		☐ ER/Outpatier	nt 3□ DOA Oth	er: 4 Nursing H	Home 5 ☐ Residenc	ce 6 Other (Spec	fy)
	ng P fter t		27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injur Worl	y at k?	28d. Describe how	injury occurred	
<u> </u>	tendle sath.	äti	2 Accident investigation			M 1□	Yes 2 □ No			
UIVISION	or Att ter de irect	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At building, etc. (Spe	home, farm, str cify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
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	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	ledical	29a. Certifier 1 ★ Certifying Ph (Check only 2 ★ Medical Examone)	nysician: To the best of my k miner: On the basis of exami and manner stated.	nowiedge, deat nation and/or in	n occurred at the tir vestigation, in my o	me, date and plac pinion, death occ	e, and due to the caus surred at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	o the o the omple	Mec	29b. Signature and title of certifier	and manner stated.		29c. License	e number	29d	. Date signed (Month	Dav. Year)
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1	4		30. Name and address of person who	· · · · · · · · · · · · · · · · · · ·	em 23a) (Type	'	-		00-10-0	U
	W		Courtney Fare				Street	Baltimore	, mo 21	201
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig		V-1	,		,	
李	Registr			60	P					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Vear **Physician** 9:20 p. 19 Charles Mickealunis, Jr. Aug. 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Nursing Center Gocial Security Number 6. Sex 7. Baltimore Towson
If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) . Age (In yrs. last birthday, **Funeral** Days Months Hours Min. **X**XM 2□ F 25, 1930 Maryland Director 213-26-5542 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, If y Madeal Examiner must be rediffed at 1 ☐ Yes 2√☐ No Director Baltimore Maryland Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7404 Fait Ave. 21224 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1/□Yes 2□No frYes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 □Yes 2 No Specify: White Specify þ ₩Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) bermit. Pages 1 and 2 should be filed with the partment of Health and Mental Hygien aportant: If them 27 is marked other thing by injury or other traumatic avent. Carpenter 9 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Mickealunis, Sr. Jean C. Kazmierski ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cynthia L. Urban (Daughter) 723 Franklin Ave. Essex, Md. 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 5 ☐ Other (Specify) Oak Lawn Cemetery 8/22/2008 Baltimore, Maryland eral Socice License Name and Address of Facility 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Procenic Immediate Cause (Final disease or condition resulting in death) CIRRAHOSIS WAVS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to fores a considuence offi Examine be executed burial-transit attending physician and Due to (or as a consequence of): Box 68760, Physician/Medical the law requires that the death certificate as IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year for in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 3 Probably 4 Unknown 1 Tes page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an las l autopsy performed? Yes 2 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Registrar

DHMH 17 Rev 1/2001

State

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2008

31. Date filed (Month

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Monti 08 2008 09:20 pM Annie T. McCormick 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death N/A Genesis ElderCare Hamilton Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) (Month, Day, Year) 05/10/1925 Months Days Hours Min. Mary land 1 □ M 2 🛛 I 219-16-7219 83 Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 XYes 2 No N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21214 3500 Mary Avenue 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🛛 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Store Owner Grocery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael A. McCormick Annie T. Parry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7922 Underhill Road, Rosedale, MD 21237 Susie Shine, Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 08/25/2008 Baltimore, Maryland Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5305 Harford Road, Baltimore, MD 21214 Immediate Cause (Final 02 DEPENDENT COPD disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death in the past 12 months?

**Physician** /Medical Examiner

physician and the burial-trans

certificate has been signed by the aftending irector, page 2 should be detached for use as

24 hours after death.

Funeral Director: After this certific letely filled in by the funeral director,

within 2 To the the

Completed by

Be

Certification: To

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

**Physician** 

/Medical

Director

Funeral

Completed by

Be

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MD

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~-: any highly or other traumatic exercises.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical

3 Ectopic pregnancy 5 Other (specify)

Month

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 knknown

Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

and manner stated.

9 Unknown

Hospital:

24a. Was an

1 Inpatient 2 ER/Outpatient 3 DOA

autopsy performed 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 ☐Yes 2 ☑No

9 Unknown

5 Pending investigation

6 ☐ Could not be determined

28b. Time of 28a. Date of Injury (Month, Day, Year)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 灯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29a. Certifier

1 Natural

2 Accident

4 Homicide

3 Suicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 28a) (Type, Print) Swite Zoh. M. P.

State Registrar 31. Date filed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SUSAN Ε. MOSSMAN 22, 2008 August 6:35 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 96 Pine Road Anne Arundel Pasadena If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Months 218-60-7540 Director Feb 4, Maine 1963 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 28a-f show "natural", or items 23a or 28a-f sl edical Examiner must be notifled Maryland Anne Arundel Pasadena 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pine Road 21122 USA Funeral Was Decedent of Hispanic Ongin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. Specify 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) 12 College (1-4or 5+) Laser Design & Mfg. Office Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stanley Joseph Tudor Margaret Lorraine Kitchner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 Is
any Injury or other trau 96 Pine Road, Pasadena, Maryland 21122 Richard A. Mossman (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Bayview Crematory Inc. 8/27/08 Baltimore, Maryland 22. Name and Address of Facility
McCully—Polyniak Fu
3204 Mountain Rd., 21. Signature of Fund ral Provice Licensee Kevin E Ecker P.A. 21122 Funeral Home, P., Pasadena, Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Buncrendic Physician CARLER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performe certificate 1□ Yes 2. No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home 1 Yes 5 Residence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours at er death To the Funeral Directoric completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 40854 MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baldinon 21202 Paul Play 227 82. Registrar's Signature <sup>Year)</sup> 2008 31. Date filed (Mo. State Magre 6 AUG Registrar

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day, Year)

Pamela E. Southall, MD Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

27196 State of Maryland / Department of Health and Mental Hygiene 2 U U 8 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Parks Brenda 7:43 2008 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) April 10,1974 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖔 F 34 217-78-2342 Yrs. Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be reaffied at once. 1 □Yes 2 No Directo Maryland Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 1933 Dineen Drive 21222 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 12 years 2 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Madeline Warner Norman Pawloski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gregory Parks Husband 1933 Dineen Drive, Dundalk, MAryland 21222 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition August 26, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. 6 not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Due to (or as a consequence or) is any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has be 2 s autops, performed: 2 No After this certificate har funeral director, page 1 ☐ Yes 2 □ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Nopatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 23a) (Type, Print)
35 NONTY Charles St. Ste 550 Balkmore MD
21204 h (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG 25

2. Registrar's Signature

3-06344		Please Ty	pe or Print in B	lack Ind	elible In	k. Ensur	e All C	opies	Are Leg	gible.		
aria Transito P		ar St	ate of Maryland	/ Depart	tment of	Health an	d Men	tal Hyg	iene		20	08 2719
	F	- For State Registrar		Certi	ficate of	Death		- 12	Re Date of Deat	g. No.		3. Time of Death
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A LAGIN		MARIA TRANSITO  4a. Facility Name (if not institution)		)	. 4t	c. City, Town, or	Location of		tagaet 10		unty of Deal	th
		501 Rappolla Street				Baltimore						
Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last	birthday)	If Under 1 Yea	_		8. Date of Bir	th (MM/DD/		irthplace (State or Foreign ountry)
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		Usual Residence of Decedent										10d. Inside City Limits
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5-0036 ed within 72 hours after lygiene. other than "natural", the Medical Examiner	d by	15. Decedent's Education (Spe	ecify only highest grade co	mpleted) 1	16a. Decedent	s Usual Occupa	ation (Give	kind of wor	k done	16b. Kind	of Business	s/Industry
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21215-0036 wild be filed within 7 Mental Hygiene. marked other than	o Be	SEGUNDO PEDRO  19a. Informant's Name/Relation			19b. Mailing	Address (Stre	et and Nur	M LUZ	TENE2	nber, City o	r Town, Sta	ite, Zip Code)
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and 2		20a. Method of Disposition		I		tion (Name of ce			Date			or Town, State
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Baltimore, Permit Pages I and Department of Healt Important: If item injury or other tra		4 Donation 5 Other S 21. Signature of Funeral Service		1	22. Na	ame and Addres						NRL. HM.
Per Per in		Molen	Chan	ff	2	007-09	FASTE	RN AV	Æ. B	LTIMO	RE, M	1D 21231
Physician		23a. Part I. Enter the disease of failure. List only one caus	or complications that cause e on each line.	d the death. I	Do not enter th	e mode of dying	, such as o	cardiac or re	espiratory are	rest, shock,	or heart	<ul> <li>Approximate Interval Between Onset and</li> </ul>
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68760 certificate b rding physi	2	23b. Was decedent pregnant in past 12 months?		one or progni		al death 3	Ectop	ic pregnand	су		onth	Day Year
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. <b>BC</b> he desy the sy the sy the shed for	h.	Part II. Other significant cond	gdikilowii	ath but not res	sulting in the u	nderlying cause	given in P	Part I.	23e. Did 1	tobacco use	contribute	to the cause of death?
P.O. Bes that the digned by the		Ture in Other Organicality Cons	contributing to do			··· <b>-,</b> ··· <b>·</b>	5		1 Ye	es 2 🗸 N	o 3 P	robably 4 Unknown
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tal Rec	S		331						1 ✔ Yes	2 No	1 🗸	Yes 2 No
tal ician: certif	Be	25. Was case referred to medic examiner?	Discoulants and	tient 2 I	ER/Outpatient		Other	h (Check or	Home 5	Residence	e 6 🗸 Ot	her Scene
Division of Vital Records, P.O. Box 68760, pital or Attending Physician: The law requires that the death certificate be expured retarth.  Heral Director: After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the burial	<u>٩</u>	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Ir		28b. Time of Ir		jury at Wor		28d. Describe			TOT. COOK
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Division Spital or Attendi hours after death. meral Director: /	ertif		uld not be ermined (Specify) S	ingle Fam	ily Home			5	or Town, 01 Rappolla	State) a Street, B	altimore,	MD
Divis  Othe Hospital or A thin 24 hours after othe Funeral Dire mpletely filled in b		29a. Certifier 1 Certifying	Physician: To the best of	my knowledg	e, death occur	red at the time,	date and p	lace, and d	lue to the cau	use(s) and n	nanner as s	tated.
To the Hosp within 24 hc To the Func completely i	Medical	one) 2 Medical Ex	aminer: On the basis of ea	kamination an	d/or investigat	ion, in my opini	on, death o	occurred at	the time, date	e and place	, and due to	the cause(s)
To T	Me	29b. Signature and title of certi				29c. Lice	nse numbe	er				Month, Day, Year)
		Cay H)	Halle	v		0.0	C.M.E.			Augus	st 20, 200	08
2		30. Name and address of person										
9		Carol Allan, MD A	ssistant Medical Ex	aminer	111 Penn 9	street, Baltir	nore, MI	บ 21201				

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		1	For State OT N  Registrar	•	epartificate of I			eg. No. 200	8 27198
	Physicia	an	1. Decedent's Name <i>(First, Middle, Last)</i> Barbara Arn Peters				Date of Deat Month	th Day Year	3. Time of Death 3:330 A. M
and the	/Medic Examin	al	4a. Facility Name (If not institution, give street and number	er)	4b. City. Town, or	Location of Death	August	21 2008 4c. County of Dear	
ژو میں	Examin	ei	Gilchrist Hospice	,	Towson			Baltimon	e
	Funeral		5. Social Security Number 6. Sex 7. /	Age <i>(In yrs. l</i> as <i>t birth</i> 66 Y		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
	Director		212-42-8685 Usual Residence of Decedent				12-12-19	241	MD
	show	ř	10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	rect	MD Raltimore  10e. Street and Number	Owings	Mills 10f. Zip Code		1	0g. Citizen of What Co	71
	th with	al Di	4 Brandywine Court		21117			USA	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Mcdical Examinat must be notified at once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Deceder Armed Force: 1 Tyes 2 If Yes, Give Year or Date:	s? XNo	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
5-0	72 ho "natur	eted	15. Decedent's Education (Specify only highest grade completed)	16a. I	Decedent's Usual Occup Give kind of work done of life. DO NOT use retired	ation during most of worki	ng	16b. Kind of Business	/Industry
121	e filed within al Hygiene. I other than ' vent, Inc. We	duc	Elementary/Secondary (0-12) College (1-40		life. DO NOT use retired Aminstrative			U.S. Gove	rment
d 2	al Hygi other vent, I	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, N	Maiden Surname)	
ylaı	should be and Mental s marked c umatic ev	70 E	John Holland			Emestine			
Mar	d 2 sho th and ?7 Is ma trauma		19a. Informant's Name/Relationship (Type. Print)  James E. Peters Jr./ Son	1.	Mailing Address (Street Brandywine Cou				Zip Code)
	es 1 and 2: of Health a of Item 27 is or other train		20a. Method of Disposition	20b. Place of I	Disposition (Name of	co Wiles I		20c. Location - City or	Town, State
Baltimore,	Page Iment ( tant: If jury or		1√ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4☐ Donation 5 ☐ Other (Specify)	e Druid Ri	Disposition (Name of crematory or other place dee cemetery			Pikesville, M	
Ball	permit. Pages 'Department of Important: If Ite any injury or of once.		21. Signature of Funered Service Lanse	`	22. Name and Addre	<sup>ss of Facility</sup> Wylie Road, Randa	Funeral	Hame P.A. of MD 21133	Baltimore Co.
. 3	Physician /Medical Examiner	<u>.</u>		sed the death. Do not line.  CUL  as a consequence of	leng an		or respiratory arr	rest,	Approximate Interval Between Onset and Death
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O. Box	attendir for use	Physician/Me		n 2 ☐ Fetal death t at time of death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	y		23d. Date of de Month	elivery Day Year
rds, P.	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death	but not resulting in	the underlying cause giv	ren in Part I.	23e. Did tol	bacco use contribute t es 2 ☐ No 3 ☐ F	o the cause of death?
Division of Vital Records,	n: The law re licate has be r, page 2 sho	Completed						med? prior to death? 2 No 1 □ Ye	utopsy findings available completion of cause of s 2 □No
Κ	Physician: r this certific ral director, I	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inp.	atient 2 ER/Out	nationt 3 DOA Oth	26. Place of Death ler: 4 ☐ Nursing Ho			ecify heapice
ion of	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: To	27. Manner of Death 28a. Date of I	njury 28b. Ti	me of 28c. Injury Wor	ry at		ow injury occurred	ecity).
Divis	tal or Atters after de al Directo	Certific		Injury - At home, fari etc. (Specify)	n, street, factory, office		28f. Location (Si City or Town	treet and Number or Fi n, State)	lural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) Certifying Physician: To the beside and manner	s of examination and	death occurred at the ti l/or investigation, in my o	me, date and place, opinion, death occur	and due to the or red at the time, or	cause(s) and manner a date and place, and du	as stated. e to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier		29c Licens	58303	2	Pod. Date signed (Mon	th, Day, Year) 21 2008
	5		30. Name and address of person who completed cause of ANOV J. CHANUS IN	n 6701	Type, Print) N= Char	les ST 7	UNSON	Avgust a  www. Z12	.64
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 5 2008	strar's Signature	harte				

DHMH 17 Rev 1/2001

08-06200 Vernon A Paige

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008

	1- For State Registrar	Certific	cate of Death	Reg.	No. 2000 211
Physician/ ledical Examiner	1. Decedent's Name (First, Middle,L	(1)	To:	August 13, 2	
	4a. Facility Name (if not institution, university Hospital	give street and nulphber)	4b. City, Town, or Location of Deal Baltimore		4c. County of Death
Funeral Director	217-13-1723 1	Sex 7. Age (In yrs. last bi	irthday) If Under 1 Year If Under 24Hi Months Days Hours Mi		MM/DD/YYYY) 9, Birthplace (State or Foreign Country) Maylard
and show any nice.	Usual Residence of Decedent  10a. State  10b. County  Maryland	V/A	Battimo	re	10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f show notified at once. al Director	10e. Sifeet and Number 2519 Southd	ere Ave.	10f. Zip Code 2/230	10g	. Citizen of What Country?
or items must be	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorce	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No ced If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? ( Siff Yes, specify Cuban, Mexican, Puerl		14. Race - American Indian, Black, White, etc.  Specify: Black
nore, MD 21215-0036 ggs 1 and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner To Be Completed by 1		y only highest grade completed) 16a College (1-4 or 5+)	a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re UN Employed		6b. Kind of Business/Industry
215-0036 be filed within 7 mial Hygiene. rked other than ent, the Medica Be Comple			18/Mother's Nan	ne (First, Middle, Ma Watt	iden Surname)
ore, MD 21215-00 ss I and 2 should be filted wit of Health and Mental Hygien If item 27 is marked other her traumatic event, the ME To Be Corr	19a. Informant's Name/Relations Chery/ Watt	-mother	19b. Mailing Address (Street and Numb of 2519 Southdere)	Ave. Ba	Himore, Many and
d & & & d	20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other Spec  21. Signature of Funer Lie Cock Lie	3 Removal from State Removal from State	e of Disposition (Name of cemetery, patory or other place)  22. Name and Address (Facility D	Date	Catonsville Marylard
	Geri	-farker	3572 F-derick	Arc. Bal-	t, shock, or heart V pproximate Interval
Physician /Medical xaminer	failure. List only one cause or Immediate Cause (Final disease or condition resulting in death)		The critical and mode of dyling, seein do curdical	or respiratory stress	Between Onset and Death
iner .	Sequentially list conditions, if any, leading to immediate cours. Enter Underlying Course	b. Due to (or as a consequence of):	-		
ceuted and transit transit		Due to (or as a consequence of):			
cian rial	UNPENDED  IF FEMALE:	AMENDED  23c. If yes, outcome of pregnance	cy		23d. Date of delivery
box 68760. The death certificate by the attending physiched for use as the butter of the box sician/Met		1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal death 3 Ectopic preg 5 Other (Specify)	nancy	Month Day Year
ires that the disippose by the detached is detached by the detached by the down Physical by Physical b	7	ns contributing to death but not result	ting in the underlying cause given in Part I.		acco use contribute to the cause of death?  2  No 3 Probably 4 Unknown
of Vital Records, P.O. ng Physician: The law requires that it ther this certificate has been signed by meral director, page 2 should be detach n: To Be Completed by				24a. Was ar autops perform 1 Yes 2	prior to completion of cause of death?
Vital Rec ysician: The his certificate director, page	25. Was case referred to medical examiner?	Hospital: 1 ✓ Inpatient 2 ER.	26.Place of Death (Chec		Residence 6 Other:
Division of Vital Records, P.O. Box 68' the Hospital or Attending Physician: The law requires that the death certifing the Funeral Director: After this certificate has been signed by the attending ripletely filled in by the funeral director, page 2 should be detached for use as direct to To Be Completed by Physician		28a. Date of Injury (Month, Day Year) Aug 13, 2008 15	b. Time of Injury  28c. Injury at Work?  1 Yes 2 No		ow injury occurred
Division o spital or Attending hours after death. Inneral Director: After y filled in by the fune Certification:	3 Suicide 6 Could 4 Homicide	not be 28e. Place of Injury - At home	, farm, street, factory, office building, etc.	or Town, Sta	reet and Number or Rural Route Number, City ate) voy Street, Baltimore, MD
To the Hospital within 24 hours To the Funeral completely filled		sician: To the best of my knowledge, of iner: On the basis of examination and/or and manner stated.	death occurred at the time, date and place, a or investigation, in my opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as stated.  nd place, and due to the cause(s)
T % F 2	29b. Signature and title of certifier	Lacour	29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) August 14, 2008
\		who completed cause of death (Item 23a stant Medical Examiner 11	a) 1 Penn Street, Baltimore, MD 212	01	
State Registra	e 31. Date filed (Month, Day, Year)	2008 32. registrar's Signature	Sports		
DHMH 17 Rev 1/2001		•	DRIGINAL	·	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2008 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death , a<u>00</u>8 Kevoa Ear unius 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Health Care System YA Maryland Social Security Number 601 this HELLY 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Oktahoma Days Months Min. 1**⋉**M 2□F 58 493-56-0459 8-31-Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 ☐ No toing 10e. Street and Number 10g. Citizen of What Country 10f. Zip Code 21802 1.5 0 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 □Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Jome Ascistant Vursing 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle Aast) Nell e100 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HOTH - randliew Lan ste 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) glasuile, M. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Baldo W. 21217 1701 Mc Culloh Nauda 23a. Part 1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Unknown neuronia WITH disease or condition resulting in death) Due to (or as a consequence of): TUMUNO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Box 68760, attending physician for use as the buria signed by the a d be detached for P.0. Records,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Experiment must be nutified at

27 Is marked other

Department of Health Important: If item 27 any injury or other trong.

**Physician** 

/Medical

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Maryland 2121

Baltimore,

2 should be filed within and Mental Hygiene.

Pages 1 and 2 Health Funeral Director

Completed by

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certificate has been s rector, page 2 should this certific al director, After this funeral of thin 24 hours after death.

the Funeral Director: Aft
ompletely filled in by the fun

Division of Vital

1 Natural 3 Suicide 4 Homicide

Physician/Medical Completed by Be ၉ Certification:

Medical

Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

examiner/ 1 ☐ Yes	2 No
27. Manner of	Death

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

AUG 2 2

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

YA Marviand Health Care System 31. Date filed (Month, Day, 32. gistrar's Signature Year)

State Registrar

To the I within 24

08-06179 Mich

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 27201

Michael Sewell	1_1	or State	State	of Marylai	Cen	tificate of	Death		,,	R	eg. No.		. •	
	Re	-!	(First, Middle,Las	st)					2.	Date of Dea Month	th Day	Year		ime of Death 2311 hrs
Physician Medical Examine			PIERRE S		R.					Month August 12	2, 2008	county of De		3111110
and the second	48	Facility Name (if	f not institution, gi	ve street and num	nber)	41	c. City, Town,		of Death		40.0	:	,,,,,,	
	H	University H					Baltimore		er 24Hrs.	8. Date of Bi	rth(MM/DI	D/YYYY) 9.	Birthpla	ce (State or Foreign
Funeral	5.	Social Security N	lumber 6.5	Sex	7. Age (In yrs. la	ast birthday)		ays Hours	Min	JULY		1	Country	MD
Director		216 <u>–96–0</u>	043	X M 2 F	29	Yrs.			اخا	זיוטט	13,	317		
*	U	sual Residence of	f Decedent 10b. County		10c. City,	Town or Location	on							d. Inside City Limits
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yland y-f sho	휘	MD 0e. Street and Nu	mber		Dr.	11111011	10f. Zip Cod	е			10g. Citiz	en of What	Country	?
rith the Maryland \$ 23a or 28a-f show a c. notified at once.	Director			7E			21217				USA			Indian, Black,
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r death v	51	1 X Never Marr	ied 2 Marrie	Yes	2 X No		Yes 2X					Specify: E	3LACI	Κ
after de	Ð.	3 Widowed		ed If Yes, Give Yea or Dates:		I 46a Doceder	t's Usual Occ	upation (Give	e kind of wo	ork done		ind of Busir		
hours matur Exami	ed l	15. Decedent's E Elementary/Sec	ducation (Specify	College (1		during m	ost of working	life. DO NO	T use retire	ed)				
36 in 72 l	ompleted		i.	Conogo (	, , ,	LABO	RER					ONST	RUCT.	ION
-00; 1 with grene fher t		11 TT 17. Father's Name	1 e (First, Middle, La	est)				l l		(First, Middle	e, Maiden	Surname)		
21215-0036 ould be filed within 72 hours after death with the Maryland a Mental Hygiene. s marked other than "natural", or items 23a or 28a-f she ite event, the Medical Examiner must be notified at once.	e e	мтснает.	P. SEWE	LL, SR.			g Address (	DIN	JA THO	OMPSON	lumber, C	ity or Town,	State, Z	(ip Code)
21; could b d Men s mar	리	19a. Informant's N	lame/Relationship	(Type, Print)		19b. Mailin	9 Address (	σ FV ΔV	7F ]	ватлти	ORE.	MD :	2121	7
MD d 2 sh Jith an a 27 i		DINA JO	HNS/MOTH	ER	20b	Place of Dispo	sition (Name	of cemetery,	<u> </u>	Date		Location - 0	City or To	own, State
ore, slan of Hee	ļ	1 X Burial 2	Cremation	3 Removal f	rom State	crematory or o		DI	08/	19/200				
Page ment ctant:		4 Donation	5 Other Speruneral Service Li	cify:	/_	KING ME	Name and Ad	dress of Fac	ilityWES	LEY CH	AVIS	, JR.	FNR	I. HM.
Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Mental H. Important: If item 27 is marked of injury or other traumatic event, the	- 1			/1//	-h.		2007 00	יייט אייט	ע געסים	VE F	TT.TAS	MORE.	MD	21231
		23a. Part I. Enter	the disease, of co	omplications that	aused the dea	th. Do not enter	the mode of o	lying, such a	s cardiac o	r respiratory	arrest, sh	ock, or hea	rt	Approximate Interval Between Onset and Death
Physician Medical		failure. List	only one cause o	<sub>a.</sub> Gunshot V										Death
miner		or condition resu	Iting in death)	Due to (or as	a consequence	e of):								
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Box 68760 e death certificate be the attending physi ed for use as the bu	N/S	IF FEMALE: 23b. Was decede	ent pregnant in the	e 1 Live	e birth	2	Fetal death		topic pregr	nancy	1	Month	D	oay Year
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P.O.	2	Part II. Other S	giiii cain oonan		5	_				1	Yes 2			pably 4 Unknown
<b>5, F</b> quires en sig	fed										Was an autopsy		p nor to o	topsy findings available completion of cause of
OFC aw rehas be	물										performed Yes 2		death? 1 ✔ Ye	es 2 No
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of Vital Records, ling Physician: The law requir After this certificate has been s fineral director, page 2 should	2	27 Manner of I	2 No Death	28a. D	ate of Injury	28b. Time	of Injury 2	8c. Injury at		28d. Des Subiect		injury occu	rred	
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Division fall or Attending after death.  "I Director: all Director: I led in by the fill	ertification:	2 Accide	6 0 0	stigation 28e. F	Place of Injury -	At home, farm,	street, factory	, office buildi	ng, etc.		Ctata	et and Num e) venue, Bal		
Division pital or Attent ours after death or action filled in by the states of the sta	it.	4 V Homic	dete	rmined (Spec	oify) Other (	front lot)								
	E   C	29a Certifier .	Certifying P	hysician: To the	best of my kno	wledge, death o	ccurred at the tigation, in my	time, date a opinion, de	nd place, a ath occurre	and due to the	, date and	place, and	due to t	he cause(s)
To the within To the	Modical	one) 2		and man	ner stated.		29	. License nu	ımber		2	9d. Date sig	ned (M	onth, Day, Year)
		29b. Signature	and title of certifi	er 10 m	10			O.C.M.E			1	August 1	3, 200	8
		ffh	u Brass	e4,111		(Item 23a)								
- d			address of perso Brassell, MD		Medical Ex	aminer 11	11 Penn St	reet, Balt	imore, N	ND 21201				
- W		D4 Date filed	(Month Day Year	3	2. Registrar's S		40 -							
	Sta	(a) ST. Date liled	IG 2 5 2	108	wes D	ignature								

DHMH 17 Rev 1/2001

Registrar

AUG 25

# Baltimore, Maryland 21215-0036

1 - Stata Registra

**Physician** 

1. Decedent's Name (First, Middle, Last)

WALTER JOSEPH SISTEK

**Physician** /Medical Examiner

burial-transit Box 68760, P.O. d be deta Records, Division of Vital

2008 JUGUST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE GILCHRIST CENTER TOWSON 8. Date of Birth (Month, Day, Year) 40 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min. 1 X M 2 □ F 212-36-7879 68 Director MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Modicial Examinar must be notified at 1 ☐ Yes 2 📉 No Director BALTIMORE MD WHITE HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20626 WEST LIBERTY RD 21161 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Was Decedent L. Armed Forces? 1 XYes 2 ☐ No 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 4YRS (1-4or 5+) Elementary/Secondary (0-12) BANKER/CONSULTANT BANKING/CONSULTANT 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) MARGARET A. HUGHES JOSEPH SISTEK 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $21161 \cdot$ CHRISTINA BEVERLY SISTEK(WIFE) 20626 WEST LIBERTY RD WHITE HALL, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State GREEN MOUNT CREMATORY 08/27/08 BALTO CITY, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HENRY W. JENKINS & SONS CO.
16924 YORK RD MONKTON, MD. 21111. Mary 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final of amplicitims Demen ten yers disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown Completed 1 Tes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2. No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 | Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and tille of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARKES - L VIDIAA 10. 6701 TENSON IND 31. Date filed (Month, Day, Year) Registrar's Signa State AUG 25 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death Month

04:30 AM

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U U 8 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) AUGUST Day ... **Physician** Year Zi Zi Zi 11:27AM Szukiewicz James M. /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death Examiner Center 7. Age (In yrs. last birthday) 52 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Day, July 29, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Hours Min. 217-76-3167 1**XX**M 2□ F Days Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" ~ ... are injury or other traumatic event. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 No Director Towson Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21286 1222 Brook Hollow Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 **XX**No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1XXNever Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Construction Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charlotte Alcantara Raymond Szukiewicz ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1222 Brook Hollow Road Towson Maryland 21286 19a. Informant's Name/Relationship (Type. Print) Richard Szukiewicz/Brother Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/25/08 Towson Maryland Service Corp. Hilltop 5 ☐ Other (Specify) 4 ☐ Donation 22 Name and Address of Facility: 5305 Hartord Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPERTENSIVE CARDIOVASCULAR DISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine s been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has lirector, page 2 s autopsy 1 ☐Yes 2 ☐No 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No aifter death. Director: 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 62312 unna 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE, MARYLAND BRANNON, M.D.

32 Registrar's Signature TOWSON. ROBERT SCOTT 31. Date filed (Month, Day, Year) AUG 2 5 State

Registrar

			Please For			ck Indelible In Department of		•	10	27205
			1 - State Registrar			Certificate o	f Death	Reg. I	2008	3 27205
*	Physicia /Medic		Decedent's Name (First, Middle, Last     ROSE	st)		SCHWARTZ		2. Date of Death Month AUGIUST	Day Year	3. Time of Death
F	Examin uneral	14	5. Social Security Number 6. S	TTAL OF	BALTE I	MURE BAL	r If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	ar) 9. Birth	/A hplace (State or Foreign
D	irector		218-07-2068		95 10c. City, To	own or Location		07/16/19	913	NY  10d. Inside City Limits
the Man)	r 28a-f sh notified	Funeral Director	MD BALT	IMORE		BALTIM(		10g.	Citizen of What Co	1 □ Yes 2 X No untry?
th with	23a o ist be	a D	8410 CARLSON LA	ANE			21244		USA	
<b>5-0036</b> 72 hours after death with the Maryland	od other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funer	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 🂢 Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	ver in U.S.	13. Was Decedent of If Yes, specify Control of Image and Image an	f Hispanic Origin? (Spuban, Mexican, Puerto o Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
Maryland 21215-0036  nd 2 should be filed within 72 hours af aith and Mental Hygiene.	than "natur he Medical E	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed)  College (1-4or 5+		Ga. Decedent's Usual Occ (Give kind of work dor life. DO NOT use reti	ne during most of work red)		. Kind of Business/	
d 21 filed wil Hygien	t, the	Con				НО	MEMAKER	- /FiA Adiddle Adeia		N HOME
and I be fil Intal H	narked other t	Be	17. Father's Name (First, Middle, Last, MAX	,	CC	LDFINGER	MARY	e (First, Middle, Maid		ERMAN
aryla should and Men	mark	2	19a. Informant's Name/Relationship (	Type. Print)	<del></del>	9b. Mailing Address (Stre		al Route Number, Cit		
and 2 and 2 ealth a	item 27 is marke other traumatic		ALLEN SCHWARTZ	/ SON		1016 W. NOR	THERN PARK	WAY, BALTI	IMORE, MD	21210
rsf	Important: If it any injury or o		4 □ Donation 5 □ Other (Specification of Funeral Service Licer 21. Signature of Funeral Service Licer 22a. Part1. Enter the disease, or complete shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused to one cause on each line	the death. D		ISTERSTOWN lying, such as cardiac	OL LEVINSO ROAD - Pl or respiratory arrest,	IKESVILLE	
Exa	chysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a a d	SEPS I	PS de Orj.				7 DAYS
P.O. Box 68760; nat the death certificate be ex	y the attending physicials iched for use as the bu	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 Live birth 2 4 Pregnant at t 9 Unknown	2 ☐ Fetal dea	ath 3□Ectopic pregna			23d. Date of del Month	ivery Day Year
rdS, P	been signed by the should be detached	d by Pł	Part II. Other significant conditions of PERT PHERA	9		, ,	given in Part I.			o the cause of death?
I Reco	ate has page 2	Sompleto	RHEUMAT ACUTE	020 ARI RENAL F				24a. Was an autopsy performed 1 Yes 2 ☑	prior to death?	utopsy findings available completion of cause of
VIta iclan:	is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		1,		h (Check only one)		
Or VITA Physician:	.s :Ē	-: To	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of Injury	y 28	Outpatient 3 DOA Coutpatient 3	Other: 4 Nursing Ho	ome 5 Residence	e 6 Other (Spe	cify)
DIVISION OF VITAL RECORDS, I or Attending Physician: The law requires the redeath.	To the Funeral Director: After th completely filled in by the funeral	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not b determined	(Month, Day	Year)	Injury V	ujury at √ork? □ Yes 2 □ No	28f. Location (Stree City or Town, S	t and Number or Ri	ural Route Number,
le Hospital	ne Funeral	Medical Co	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	nysiclan: To the best of niner: On the basis of and manner stat	examination	dge, death occurred at the and/or investigation, in m	e time, date and place by opinion, death occu	and due to the caus rred at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
To th within	To th	Me	29b. Signature and title of certifier  S. Rakus	~ /	MO		onse number 90 6694 6		Date signed (Mont	
3			30. Name and address of person who RAKESH SURAT	completed cause of de	ath (Item 23	a) (Type, Print) 2401 WEST	BELVED	CRE I	BALTZMOE	7/ 2008 26/ MARYLAM 21215
	Sta Registi		RAKESH SURAT 31. Date filed (Month, Day, Year) AUG 2 5 2008	32. Registra	rs Signature	Garle				

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Immediate Cause (Final	lications that caused the death. Do not enter the mode of dying, such as one cause on each line.  ATHERUSCLEROTIC CARDIOVI	B	Approximate Interval Between Onset and Death
disease or condition resulting in death)	Due to (or as a consequence of):	7,304,77,70	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b		
that initiated events resulting in death) Last	c		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown	23d. Date of deliver Month	ry Day Year
Part II. Other significant conditions of	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the	
		autopsy prior to con performed? death?	sy findings available pletion of cause of
25. Was case referred to medical examiner?	26. Place	of Death (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nut	rsing Home 5 ☐ Residence 6 ☐ Other (Specify	)
27. Manner of Death	28a. Date of Injury (Month, Day, Year)  28b. Time of Sec. Injury at Work?  Injury  M  1 □ Yes 2 □ N	28d. Describe how injury occurred	
1	12100 221		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008

4c. County of Death

BALTIMORE

USA

16b. Kind of Business/Industry

OWN HOME

RANDALLSTOWN, MD

14. Race - American Indian,

WHITE

UNKNOWN

5:50

Birthplace (State or Foreign Country)
 NiD

10d. Inside City Limits

1 ☐Yes 2 No

РМ

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

32. Registrar's Signature

28595

Smith ArE, SUITE 203

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 2:45 a. M 20, 2008 Bobby E. Tate Aug. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Middle River 505 Grovethorn Road 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Hours Days 1 X M 2 □ F Oct. 12, 1930 West 236-48-8720 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Middle River Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21220 505 Grovethorn Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐Yes 2 🛛 No Specify: Specify: 3 √Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Railroad 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maude (Unknown) Thomas Tate 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lexington Pk., Md. 20653 47185 Schwartzkopf Dr. Robert Tate (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Serv. Corp. 8/25/2008 Towson, Maryland 21. Sign Ture of Funeral Service Licensee 22. Name and Address of Eacility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 Approximate Interval Between Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, , or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 1No 1 ☐ Yes 1 Yes 26. Place of Death (Check only on ) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

physician and the burial-transit death certificate be executed P.O. Box 68760, as t the attending for use detached signed by the detach Division of Vital Records, cate has been si page 2 should b Physician: funeral director, After this or Attending death. after death Director: completely filled in by the

**Physician** 

/Medical

10a. State

Directo

Funeral

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Be

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Examine

Physician/Medical

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Completed

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Certification: To

Medical

Examiner

**Funeral** 

Director

7 Is marked other than "natural", or items 23a or 28a-f shor traumatic event, Ite Medical Examir or must to modified at

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event service."

Physician /Medical

Examiner

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Philadel phia 7d St. 314

1241

Hospital within 24 hours a

To the

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2008 AUG 25

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 22. 2008 8:45 Рм Treva Jennings Watts 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Middle River 13 Dihedral Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/25/1919 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In vrs. last birthday Hours Min. Months Davs 1 □ M 2KX 89 238-12-0322 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Baltimore Middle River Maryland 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21220 U.S.A. 133 Dihedral Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1 ☐Yes 2√2 If Yes, Give Year or Dates: 2/2XNo 1 Never Married 2 Married Specify: White 1 □Yes XXNo 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Western Electric Co. Solderer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nannie Rector Fred Jennings 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Helicopter Drive, Baltimore, Maryland 21220 Mark Watts (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Zion Church Cem. 08/25/2008 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland 22. Name and Address of Eacility Bruzdzinski Funeral Home, P.A. 21 Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 Pari 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest short, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immed te Cause (Final dise te or condition resulting in death) morri Due to (or as a cons Due to (or as a consequence of) Due to (or as a consequence of): yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

Physician /Medical Examiner

and

attending physician

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been signed be should be deta

completely filled in by the funeral director,

within 2 To the

Physician/Medical

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Completed

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Certification: To

Medical

B Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
P Hours after death.
P Funeral Director: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

uth and Mental Hygiel 27 is marked other the traumatic event, the

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked oth any injury or other traumatic event once.

Director

Completed by Funeral

Be

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner

24a Was an autopsy performed? 1 □ Yes 2 No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes

25. Was case referred to medical examiner? 1∐Yes 2XNo

28a. Date of Injury (Month, Day, Year)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Specify

27. Manner of Death

1 Natural
2 Accident 3 Suicide 4 ☐ Homicide 5 Pending investigation 6 ☐ Could not be

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14ha 32. egistrar's Signature 2°5

State Registrar

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 20 **Physician** AUGUST 2008 3:32A WEINSTEIN /Medical 4a. Facility Name (If not institution, give street and number ASST ID LIV. 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RENAISSANCE GARDENS @ RIDERWOOD MONTGOMERY SILVER SPRING 8. Date of Birth (Month Day Year) 03/17/1920 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Months Days Hours MD 219-03-0149 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 □Yes 2 No Director SILVER SPRING MONTGOMERY MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with USA 20904 3160 GRACEFIELD ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify: \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) CAPITOL AUTO PARTS OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be IDA NATHANSON WEINSTEIN SAMUEL 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3160 GRACEFIELD ROAD, SILVER SPRING, MD of Health BERNICE WEINSTEIN / WIFE permit. Pages 1 and Department of Heal Important: If item 2 any injury or other 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 08/22/2008 BALTIMORE, MD BETH TFILOH CONG. 5 Other (Specify) Signatur 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death Part 1 Enter the disease, ir complications that caused the defin. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirting, or heart failure. List only one cause on each line. Immediate Cause (Final Physician **HEMOTHORAX** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician at the burial. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) the 1 ☐Yes 2 ☐ No. 9 Unknown signed by the bestach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ PARKINSON'S DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performed? 1 □ Yes 2 🗖 No certificate 2 🗆 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? ASSISTED Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Spec Certification: To After thi funeral LIVING 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu death. 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled 29a. Certifier 1 🐧 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 08/20/2008 D24035 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MACHADO, 3110 GRACEFIELD ROAD, SILVER SPRING, MD 20904 2. Registrar's Signature 31. Date filed (Month, Day, Year) State **AUG 2 5** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death **Physician** RANNELL L. YATES 9:48A. 2008 August 16. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Memorial Hospital Cumberland
If Under 1 Year | If Under 24 Hrs. **Allegany** 8. Date of Birth (Month, Day, Year 10/22/1965) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1**X** M 2□ F Yrs. WASHINGTON, DC 218-94-5588 42 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County at 1 XYes 2 No Examiner must be notified Director DC WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or 3532 CLAY ST., N.E. 20019 UNITED STATES filed within 72 hours after death Hygiene. by Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X r than "natural", or the Medical Examin 1 ☐ Yes 2X No Specify: BLACK Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) LABORER PRIVATE 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) NORMAN YATES JOAN GASKINS 19a. Informant's Name/Relationship (Type. Print) GLORIA L. LEWIS/SISTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 716 EAST OLDTOWN RD CUMBERLAND, MD. 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BELTSVILLE, MD. 4 Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY: 9/2/08 22. Name and Address of Facility CAPITOL MORTUARY 21. Sign ture of Funeral Service Licenz 1425 MARYLAND AVE. N.E. WASH. 23a. Pan 1. Enter the disease, or complications that caused the dean. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【XNo 24a. Was an To the Hospital or Attending Physiclan: 25. Was case referred to medical 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dipatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 1 Natural funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending ours after death.

neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No Investigation 2 ☐ Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 1 [Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, AUG 2 5

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aruland

29c. License number

D0066606

Health

29d. Date signed (Month, Day, Year)

2008

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AMEND ITEM#1, perPHYS, G882, 8/25/08, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) William A. Aisquith Jr. 2. Date of Death Day Year () & **Physician** 15 Oct 171 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PASADENA CT. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Min. 1**X**M 2□F Days Months Hours Yrs 50 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count show a or 28a-f show t be notified at 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 8100 EL Items 23a MRERRY CT. "natural", or Items 23a edical Examiner must by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 72 (Give kind of work done during most of working life. BO NOT use retired) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "I any Injury or other traumatic event, the Med any Injury or other traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Be Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Nu or Town, State, Zip Code) SAJENAMD. 21122 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State FANONER, MD. 4 □ Donation 5 □ Other (Specify) f Fun 21. Signatur Part1. Enter the disease, shock, or heart failure. complications that conly one cause on e enter the mode of dying, such as cardiac Approximate Interval Between Onset and Death Immediate Cause (Final 1 lem **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? signed by the at Id be detached for 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 3 Probably 4 ☐Unknown 1 ☐ Yes 2 □ No been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? Yes 2 100 certificate 1☐ Yes or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 2 this funeral To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 XNatural 2 ☐ Accident 5 Pending investigation 1 □ Yes 2 □ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of dertifier 29c. License number 29d. Pate signed (Month, Day, Year) 11,2008 Name and address of person who completed cause of death (Item 23a) (Type, Print) MM FENSE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 5 2008

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 4:58 PM Clara Mae 29 08 Brown /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chester River Manor Chestertown, Kent If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 F 1-12-1920 239-32-0710 88 SamsonCo, Director NC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No MD Kent Worton be notified Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 6 P.O. Box 63 21678 US items 23a 7 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 and Mental Hygiene.
7 is marked other than "1 Elementary/Secondary (0-12) College (1-4or 5+) Owner Operated Nursing Hm 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Calvin Swinson Lila McCalop ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any injury or other traum 526 High St Chestertown, Peter Clements Guardian MD20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8-09-08 4 Donation 5 Dother (Specify) Jane Cemeterv Chestertown, MD 21. Surrature of Funeral Service Licenses 22. Name and Address of Facility Bennie Smith FH-717 W. Division St Dover 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on jach line. Immediate Cause (Final disease or condition resulting in death) ear) Physician FRYID 7 C /Medical Due to (or as a consequence of): **Examiner** le vs 64 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9 Unknown 9 Unknown been signed by should be detacl 23e. Did tobacco use contribute to the sause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an page 2 s autopsy perform 2/2 No certificate 1□ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 2No Certification:/To 1 ☐ Yes 2 ER/Outpatient 3 DOA After this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8

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State

Registrar

Mh.

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

**20**08 ▶

32. Registrar's Signature

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31. Date file (Month, Day, Year)

completely within 2

State Registrar 29b. Signature and title of certifie

AUG 0 8 2008

30. Name and address

PETER M. SCHISSLER M.D. 7500 GATEWAY CENTER DR. # 430 GREENBELT, MARYLAND 20770 31. Date filed (Month, Day, Year)

32. Registrar's Sign

and manner stated.

person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D22780

29d. Date signed (Month, Day, Year)

AUGUST 5, 2008

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Registrar Amen 347 Per FLIDOS 8 0800

1. Decedent's Name (First, Middle, Last) Certificate of Death 2. Date of Death **Physician** 30 /Medical 4b. City, Town, or Location of Death Examiner heverly Year | If Under 24 Hrs 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🗷 F 56 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No andover Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 20785 Funeral permit. Pages 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene. Important: If flew 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must Race - American Indian Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 PNo þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLOMESTIC HOUSE KEEPER Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LONGOVER, MI). 20185 hus band 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ilen wood ( WASHINGTON, D.C. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 2. Henry 23a. Part1. Ent. I the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ARDIOVASCULAR DISEASE **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy should be detached for in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) □Yes 2 III No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 'ARDIOMYODAthy 2 No 3 Probably 4 Unknown Completed Near Failure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an funeral director, page 2 autopsy performed? Yes 2 2 No Hypertension 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 2 ER/Outpatient 3 DOA this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Ecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapner stated. one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and a ress of person who completed cause of death [flem 23a] (Type, Print) HOSPITAL DR., Cheverly MD. 20785 attarian 32. Registrar's Signature 31. Date filed (Month. Day State AUG 0 8 2008 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12, Helen Madalene Burner 2008 6:15 A.M August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Golden Living Center Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 13, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**Y** □ F 84 1924 Maryland 212-24-6686 Director June Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural" or them. The marked other than "natural" or them. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 750 Dual Highway 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eric Seth Moser Edna Ellen Marshall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald C. Richardson Nephew 12215 West Lawn Lane, Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08-15-08 Rest Haven Cemetery Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Andrew K. Coffman Funeral Home, Inc. hoel Brady 40 East Antietam Street, Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 6 weeks /Medical Due to (or as a consequence of): **Examiner** Lenovosculon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1. Natural 2 Accident To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-05966 2008 27216 State of Maryland / Department of Health and Mental Hygiene amend #5 Per FH G882 eftificate of Death Philip Brittingham 1- For State Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 1024 hrs August 4, 2008 <sup>1</sup> Examiner Philip MY Alan Brittingham 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Wicomico Salisbury 1005 Adams Avenue Apt I 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5 Social Security Numbe 217-36-1294 2<del>17-35-129</del>4 **Funeral** Months Hours Min. Days Director X Country) 2 F Yrs 69 /2/1938 Maryland Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location any 10a. State 10b. County X Yes 2 No or 28a-f show once. Maryland Wicomico Salisbury should be filed within 72 hours after death with the Maryland and Mental Hygiene. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code s 23a or 28a-1005 Adams Avenue, Apt. I 21804 USA 14 Race - American Indian, Black, 펻 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 11. Marital Status t: If item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner must be Funer If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 X Married 1 X Yes No Specify: White Divorced If Yes, Give Year Yes 2 X No specify: 3 Widowed Army ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 <u>Postal Clerk</u> Postal Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Howard Hitchens Be Helen Moore Pages 1 and 2 should be ment of Health and Ment ant: If item 27 is mark 10 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4654 South Wood Terrace Salisbury, Maryland 21804 ce of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Barbara Brittingham/wife 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) X Burial 2 Cremation 3 Removal from State Parsons Cemetery 8/9/2008 Salisbury, Maryland Important: 10 Donation 5 Other Specify permit. Signature of Funeral Service Licensee 21804 Maryland Approximate Interval 23a, Part I, Enter the disease, or complica hysician Between Onset and failure. List only one cause on each **Viedical** Death a, Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease ⊭xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed sician/Medical attending physician for use as the burial -UNPENDED AMENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown detached for Unknown the Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown ð Completed 24b. Were autopsy findings available page 2 should 24a. Was an has been prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 No No certificate 26.Place of Death (Check only one 25. Was case referred to medical Be Hospital: 1 Other: examiner? DOA Inpatient 2 ER/Outpatient Nursing Home 5 Residence 6 V Other: Scene this 1 🗸 Yes ٩ No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28b. Time of Injury After 27. Manner of Death Certification: 1 V Natural Division 1 Yes 2 within 24 hours after death. To the Funeral Director: Pending in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 Suicide or Town, State) filled determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number August 5, 2008 O.C.M.E. MOD 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ling Li, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) State Registrar COME

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2	filed within 72 hours after death with the Maryland Hygiene. other then "neturel; or Items 23e or 28e-f ehow ent, the Medical Examiner must be notified at		12. Father's Name (First, Middle, Las	4+	□ Ge	eneral S	urge		er's Name (First,		Maiden Sumame,		
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Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene item 27 is marked other then "neturel", or liems 23e or 28e-f show other treumetic event, Its Medical Examinations to notified at	ဥ	19a. Informant's Name/Relationship		19	b. Mailing Addre	ss (Street				. City or Town, S	tate, Zip	Code)
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ē,	t Health tem 27 other tr	1 8	20a. Method of Disposition		20b. Place	of Disposition (Nery, crematory of	ame of other pla	ce)	Date		20c. Location - C	ity or To	wn, State
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l-md	lospitel hours a unerel E	C	29a. Certifier 12 Cartifying 8	Physician: To the be	st of my knowled	ige, death occurr	ed at the t	time, date a	nd place, and du	ue to the	cause(s) and mar	ner as s	tated.
	To the Hospitel or Attence within 24 hours after death To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Ex-	aminer: On the basis and manner	of examination stated.	and/or investigat	on, in my	opinion, de	ath occurred at t	the time,	date and place, a	na que to	tne cause(s)
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14	1 HA		30. Name and address of person wh	o completed cause of	f death (Item 23a		^			e h		,	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month BARKLEY **Physician** HELENA SMAN 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospice at the Lake Salisbur Jicomico If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) 3 - 7 - 1938 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Days Months Hours 1 ☐ M 2 🕱 F M. 214-34-6199 70 Director ARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director Wicomico 1⊠Yes 2 No Alisbury ARY/AND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? GATEWAY 21801 USA 915 14. Bace - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic NONE Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental em 27 is marked o Curtis Dullon Norwood KENAGER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RENAGEE 401 Moss Hill PAYONTER LA. Mg 21601 DALISDURY. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ⊠Burial 2 ☐ Cremation 8--08 4 □ Donation 5 □ Other (Specify) Alisbury ≥ Drina 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WESTRA (1)( Sladys B FUN ERA! HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or his rifailure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** anc /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical for use as IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) 2 Fetal death 1 ☐ Live birth in the past 12 months? 1 ☐ Yes > ☐ No Month Day Year 4☐Pregnant at time of death detached 9 Unknown 9 Unknown s been signed by til 2 should be detach Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ☑ No 24a. Was an page 2 s autopsy performe certificate 2 1 No 1∐ Yes Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/2-No Impatient 1 ☐ Yes 3□ DOA 2 ☐ ER/Outpatient Medical Certification: To funeral c 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After or Attending **1.** Natural Injury 5 Pending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital t Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) String wy COUSTITZ HUNAN 31. Date filed (Month, Day, Registrar's Signature Year) State Registrar 2008 AUG 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#17,18, per FH, G882,8/25/08, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Aug 17, 2008 5:30am Mae Benson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Allegany Sincerely Yours Assisted Living Ctr. Cumberland 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 4, 1934 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex Funeral Country 1□M 2□F Months Davs Hours Director 217-30-1227 Usual Residence of Decedent the Maryland 10c. City, Town or Location ns 23a or 28a-f show must be notifled at 10a. State 10b. County 10d. Inside City Limits Allegany Cumberland MD Y☐Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner must be no once. 21502 USA 11209 Sunrise Avenue SE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: white ģ 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health & Welfare Dept. Teamsters Local 453 17. Fathwallter Gerber Delozier Walter Gerber De Loyler 18. Mona's lane First Mille Marge Funzire -Elizabeth June De Loyler Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 14211 Stonefield Lane, Cumberland MD 21502 Walter Benson son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sunset Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 8/20/2008 MD Cumberland 4 □ Donation 5 □ Other (\$pecify) 21. Signatur of Furreral & 22. Namescafpeffispuffielfal Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death Physician 0 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician ar s the burial-t Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical SS IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has birector, page 2 s autopsy performed? 2 NO To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Beath (Check only one) 2 No Hospital: 1 ☐ Yes Other: 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this after death.

I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manuar of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 / Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 W. Leon Stork

State Registrar

Alte à = 2000

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

			1 - For State Registrar	State of Mai		rtificate of			eg. No.	
	Physici	an	Decedent's Name (First, Middle, Last					2. Date of Deat Month	Day Year	3. Time of Death
	/Media	al	John W. Body			4h City Tourn o	Location of Death	August	13,2008 4c. County of Dear	1443
	Examir	ier								
_	Funeral		Holy Cross Hos  5. Social Security Number 6. Se		(In yrs. last birthday)	Silver If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day)	Montgon 9. Bird	thplace (State or Foreign
В	Director		5/8-52-65/2	<b>X</b> M 2□F	68 Yrs.	Months Days	Hours Min.	Sept.2	5,1939 V	Wash.,DC
	land w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	ter death with the Marylar Iteme 23e or 28e-f ehow Iter must be motified at	ģ	DC		Washing	rton				1 TyYes 2 ☐ No
	r 28s	Director	10e. Street and Number		Wasiiiii	10f. Zip Code		1	0g. Citizen of What Co	ountry?
	23a o	a D	4201 Butterwor	th Place.	NW	2001	6		United St	tates
	r dea	Funeral I	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of H	ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	rs afte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	)	1 ☐ Yes 2 🔀 No	Specify:		Specify: D1	a ak
21215-0036	J within 72 hours after death with the Maryland Jene. r then "natural", or iteme 23a or 28a-f ehow Ita Medical Exaction rmust be positied at		15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Business	ack /Industry
2	hin 72 an "na Marali	Completed	(Specify only highest gra	de completed)  College (1-4or 5+	life.	kind of work done DO NOT use retired	during most of work f)	ing		
7	77 25 4 25	Son	11			Drive			Priva	te
2	習慣り	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			
2	d 2 should the and Ment 7 is marked traumatics	ဥ	Junes Body  19a. Informant's Name/Relationship (1)	Sun a Brine)	10h Mailin	- Address (Street		illiam:	S r, City or Town, State, .	7in Codel
Maryland	2 2 2 2	1			9879	Good I	uck Roa		, Chy or Town, State,	LIP COGE)
	s 1 end 2 f Health item 27 other tra		Tonya Fisher/da 20a. Method of Disposition	-		nam, Md.		Date	20c. Location - City or	Town, State
Ē	Pages nent of int: if it		T Gurial 2 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Riverdale Md. Nati	"Park"Cre	matory 23	3 708	Riverdale <del>Laurel</del>	Md.
baitimore,	permit. Pages Depertment of I Important: If its eny injury or o		21. Signature of Funeral Service Licen		22	2. Name and Addre	ss of Facility HO	dges &	Edwards Suitland,	F.H.
			23a. Part 1 Enter the disease, or compshook, or heart failure. List only	olications that caused the					······································	Approximate
	Physician		Immediate Cause (Final							Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		<u>Terniatio</u> consequence of):	on				
	Examiner		Sequentially list conditions	, Brain E	dema					
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):				200	
	and I-trans	хаш	that initiated events resulting in death) Last		consequence of):	ovascula	r Accid	ent of	the Righ	t Hemisph
08/00	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	a E		4						
000	ificate g phy: as the	edical		, a.						
X Q Q	ih cert endin r use	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		Ectopic pregnancy			23d. Date of de	
	ne deal the att	sicia	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at ti 9☐Unknown		Other (specify)			Month	Day Year
	that the		Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderhing cause gru	an in Part I	23e Did to	bacco use contribute t	o the cause of death?
GS,	signe d be d	d by	Atherosclerosi	9				1 Z Y		robably 4 Unknown
Š	w requir been s should	Completed	Malignant Hype		aboutur	DIDOGO		24a. Was a	n 24b Were a	utopsy findings available
Vital Records,	The lar	d Ho	Diabetes Melli		2			autop: perfor	sy prior to meg? death?	completion of cause of
<u> </u>		0	25. Was case referred to medical	cus Type			26. Place of Deat	1 ☐ Yes		2/11/0
0 0	Physician: this certific ral director,	To B	examiner? 1 □ Yes 2 ☑ No	Hospital: 1 / Inpatien	t 2 ER/Outpatier	nt 3 DOA Oth	er: 4 🗌 Nursing Ho	ome 5□Resid	ence 6 Other (Spe	əcify)
	5 9 E		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wor		28d. Describe h	ow injury occurred	
DIVISION	Attending r death. sctor: Alter by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be		v. At home form str		Yes 2 No	28f Location /S	treet and Number or R	lucal Boute Number
2	isi or Attendii s after death. al Director: A ad in by the fu	Certification:	4 Homicide determined	building, etc.	y - At home, farm, str (Specify)	reet, ractory, office	1	City or Tow		urai nodie ivanber.
	Hospit 24 hour Funera tely fills	Medical C	29a. Certifier Check only one) Check only	ysician: To the best of niner: On the basis of and manner state	examination and/or in	h occurred at the tile vestigation, in my o	ne, date and place, pinion, death occur	and due to the d red at the time, o	ause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifie	and mailler state	-	29c. Licens	e number	4	29d. Date signed (Mon	th, Day, Year)
)	F 3 F ō		· AA			MD47	1867		August 14	2008
			30. Name and address of person mig	completed cause of de	ath (Item 23a) (Type,		307		angube 15	., 2000
			Onev Zuniga 4	701 Rando	lph Rd.	#216. R	ockvill	e, Md.	20852	
	Sta		Oney Zung ga 4 31. Date filed (Month, Day, Year) AUG 25 2008	. 32. Registrar	's Signature	Dr.				
	Regist	eir	MUU G J LUUB	Paratoria P	Almana					

State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 12:12 a. Monty W. Burdette 2008 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Westernport
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Moran Manor Nursing Home Allegany 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreig Country)
April 17,1934 Marfrance, WV Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sax **Funeral** 1**∑**M 2□F Months Director 212-30-3941 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heathh and Mental Hygiene.
Instit fitem 27 is marked other then "netural, or Itams 23a or 28a-f show my or other then "netural, or Itams 12a notified all my or other traumatic event, the Medical Engine 1 ☐ Yes 2 No Director Mineral Burlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rt. 1, Box 186-H 26710 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1954–58 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 □ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self employed Fork Lift Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert M. Burdette Violet M. Hoke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 is any injury or other trau once. Esther M. Burdette/ Wife Rt. 1, Box 186-H Burlington, WV 26710 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Aug. 23 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2008 \* 4 ☐ Donation 5 ☐ Other (Specify) The Cumberland Crematory Cumberland, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) and3 tall Physician irems /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed the attending physician and the for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No should be detached 9 Unknown 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Saknown De Scaso Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 1 ☐ Yes 2 🎇 No or Attanding Physician: ector, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of After 1 ZNatural 2 ☐ Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To tha Funaral Diractor: A investigation 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 determined 4 Homicide To the Hospital 29a. Certifier 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D21244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 Jesus Tan, M.D. 4 Broadway Frostburg MD 21532 31. Date filed (Month, Day, Year)
AUG 2 5 2008 32/Registrar's Signature State Registrar

	920		For State Registrar	State of Ma	iryland	/ Depa <i>Cer</i>	tificate of	Death	Viental Hy	Reg. No	<u> </u>	2722
	Physici		1. Decedent's Name (First, Middle, Last, Pamela Jean Carte						Month August		<sup>y</sup> 2008 <sup>Year</sup>	4:10 A M
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	r Location of Deat			. County of Death	
			26582 South Sands					nicsvill			St. Ma	
	Funeral Director		200-04-9313	7. Age M 2127 F	38	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da August 3	rth a <i>y, Year)</i> 31, 19	9. Birthp Coul	place (State or Foreign ntry) Ohio
	show	'n	Usual Residence of Decedent  10a. State  10b. County  Maryland  St. Ma	ary!a	10c. City, T	own or Lo		hanicsvi	110	_		10d. Inside City Limits 1 ☐ Yes 2 No
	the M 28a-f otifie	Director	10e. Street and Number	ily S			10f. Zip Code	Hanitesvi	116	10a. Cit	tizen of What Cour	intry?
	ag or		26582 South Sands	ates Road	1		206	59			USA	
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event. The Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 ☒Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2X N If Yes, Give Year or Dates:	er in U.S.		Was Decedent of H f Yes, specify Cub I ☐ Yes 2X No		pecify Yes or No to Rican, etc.)	0-	14. Race - Americ Black, White, Specify: Whi	, etc.
ž	2 hou natura ical E	ted	15. Decedent's Edu	cation	1	16a. Deced	lent's Usual Occup	pation	rkina	16b. K	and of Business/In	ndustry
7	ithin 7 se. nan "r Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	lite. I	OO NOT use retire	d)	iking	Plas	stic Manu	ufacturer
Ž	led will have the her the her the	ပ္ပ်	12			Labor	er	18. Mother's Nar	mo /First Middle	Maidar	2 Surnama)	
	ntal F ed otl	Be	17. Father's Name (First, Middle, Last) William Davenport	t Carter					,		beth Kes	sler
Š	thould Me Me mark	은	19a. Informant's Name/Relationship (7)			19b. Mailir	a Address (Street				or Town, State, Zij	
<u>2</u>	nd 2 s lith ar 27 is r trau		Hazel B. Knott /				-					le, MD 2065
Ď,	of Hea		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name of natory or other pla	ce)	Date		ocation - City or T	
Daltillion	it. Page intment c intant: If injury or		1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			opolit	an Crematon	Augu	1st 14, 2008		xandria, V	irginia ————
מ	Depa Impo any I		Thehaet 1	ardine	n		Mattingle P.O. Box	y-Gardiner 270 Leon			P.A. 650	
			23a. Part1. Enter the disease, or somp shock, or heart failure. List only o	cations that caused na cause on each lir	the death. ne.	Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ovari			r					
	Examiner	P.	Sequentially list conditions,	b. Due to (or as	a consequer	nce of):						
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter thoderlyin. Cause (Disease or injury	,								
,00/00	certificate be executed iding physician and ise as the burial-transit	edical Exa	that initiated events resulting in death) Last	Due to (or as	a consequer	nce of):						
	rtificat ng phy as th		LIE EENIN E						-			
O. DOX		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	eath 3 [	Ectopic pregnanc Other (specify)	у			23d. Date of delive Month	very Day Year
, v	law requires that the death as been signed by the atter 2 should be detached for u	by	Part II. Other significant conditions co	ntributing to death be	ut not resultii	ng in the u	nderlying cause giv	ven in Part I.		tobacco		the cause of death?
secords,	2 88 2	Completed							24a. Wa:	s an opsy formed?	24b. Were aut prior to co death?	topsy findings available ompletion of cause of
2	r: The licate har, page								1□ Yes	2 <b>K</b> ] N		2 No
\ [G	Physician: The law r this certificate has b ral director, page 2 s	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 🖾 No	Hospital:	O	7/Outpotion	t all DOA Ott	ner:	ath (Check only		a 🗆	· · ·
ō	Phy rald	5	27. Manner of Death	28a. Date of Inju		8b. Time o	IL 3 L DOA	4 LI Nursing i	28d. Describe		6 ☐Other (Specury occurred	ity)
SION	Attending or death. ector: After by the fune	ţi	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	y Year)	Injury		rk? ]Yes 2 ⊟No				
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injubulding, etc.	ury - At homo	e, farm, str	eet, factory, office		28f. Location City or To	(Street a own, Stat	nd Number or Rui te)	ral Route Number,
	ne Hospit 24 hours ne Funers pletely fille	edical (		rsician: To the best iner: On the basis of and manner sta	f examinatio							
	To ti withi. To ti	Me	29b. Signature and title of certifier	20			29c. Licens	se number 00557	51	29d. Da	ate signed (Month	
			30. Name and address of person who color Jennifer Schmid				Print) nants Lar	ne Leor	nardtown	, MD	20650	
d	St	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signatur	re						
DI	Regist	rar	AUG 1 3 2008	See St. Hegistr	Ano				-			

DHMH 17 Rev 1/2001

			For State Registrar	e of Maryland / Depa Cer	tificate of Death		ene 2008	27223
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  John Richard Crow	ley		2. Date of Death Month August	9, 2008 Year	3. Time of Death 8:45 A. M
	Examir		4a. Facility Name (If not institution, give street an 11740 Asbury Circle,		4b. City, Town, or Location of Death <b>Solomons</b>		4c. County of Death  Calvert	
	Funeral Director		5. Social Security Number 6. Sex 11 M 2	7. Age (In yrs. last birthday)  88 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, 1) 08–17–1	9. Birthp (ear) 9. Birthp Court 919 IL	elace (State or Foreign htry)
·	Di .	ctor	Usual Residence of Decedent	10c. City, Town or Lo	cation	, 40 1, 1		0d. Inside City Limits 1
	with the	I Dire	10e. Street and Number 11740 Asbury Circle,	Apt. #1501	10f. Zip Code 20688		g. Citizen of What Cour <b>United Sta</b> t	•
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ted by Funeral Director	1 ☐ Never Married 2 Married 1 1	Yes 2 No s, Give or Dates: WW II	Vas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto ☐ Yes 2[X] No Specify: ent's Usual Occupation	16	14. Race - Americ Black, White, Specify: Wh:	etc. ite
1215	within 7, ene. than "n	Completed		ege (1-4or 5+)	kind of work done during most of work		Wowld Dank	
nd 2	12 should be filed within "h and Mental Hygiene." I's marked other than "I raumatic event, the Mec	Be Co	17. Father's Name (First, Middle, Last)		Bank Executive 18. Mother's Name	e (First, Middle, Ma	World Bank aiden Surname)	_
Maryland	d Menta narked natic e	To E	Edward Michael Crowle			La Flamm		Codel
	nd 2 st alth and 27 Is n		19a. Informant's Name/Relationship (Type. Print Hazel N. Crowley (Wif		g Address (Street and Number or Rur Asbury Circle, A			,
Baltimore,	t. Page rtment c rtant: If		20a. Method of Disposition  1  Burial 2  Tremation 3  Removal 4  Donation 5  Other (Specify)  21. Signature of Funeral Service Licensee	Metropol:	itan Crematory 8/	11/08 A	Oc. Location - City or To Alexandria, uneral Home	Virginia
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50,	Physician and physician and physician and physician and stree burial-transit	Il Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	that caused the death. Do not enter on each line.  Let to (or as a consequence of):  Let to (or as a consequence of):	er the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
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Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outpatien	Other	th <i>(Ch</i> eck only one,	) nce 6 □Other (Specin	6/)
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical C	(Check only 2 Medical Examiner: On		n occurred at the time, date and place, vestigation, in my opinion, death occur			
	To th within To th compl	Me	29b. Signature and title of certifier	W/B	29c. License number		d. Date signed (Month, August 11,	
de	14016		30. Name and address of person who completed Eric Berg, MD -110 Hos	cause of death (Item 23a) (Type, spital Rd., Suit	Print) e 310, Prince Fre	derick, N	MD 20678	

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day AUG 1 8

State of Maryland / Department of Health and Mental Hygiene? [] [] [] Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup>2008 AUGUST 3 **Physician** 7:55 A M CRAIG ROBERT /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ST. MARY'S LEONARD TOWN CHARLOTTE HALL NURSING HOME | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | FEB 2 1921 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** CHICAGO, IL 1⊠M 2□F Director 416-14-7701 87 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State e filed within 72 hours after death with the Marylan al Pygiene other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show vent, the Medical Examinat mant be notified at 14TYes 2 No LEONARD TOWN MD Director ST. MARY'S 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20627 CHARLOTTE HALL ROAD 29449 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. XYes 2 ☐ No Yes, Give 1 Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by 3 Nidowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) GOVERNMENT SUPERVISOR 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event OMCE. **EVANS** BLANCHE FRED JORDAN ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 7806 SHALLOW BROOK COURT SEVERN, MARYLAND 21144 MINNIE JACKSON/COUSIN 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 □ Rurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) LANDOVER, MARYLAND 8/11/2008 HARMONY CEMETERY 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OF **Physician** ARCINOMA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires thet the death certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, HYPERTENSION SSENTIAL 1 Yes 2√2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? MELLITUS 24a. Was an autopsy 2 ☐ No 2 No 1 Yes 1 Yes 26. Place of Death | Check only one 25. Was case referred to medical examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 1 ☐ Yes \_ 2 💽 No 28b. Time of Injury After the funeral 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours after d To the Funeral Diract completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D67788 2008 MD

Registrar DHMH 17 Rev 1/2001

State

29449 CHARLOTTE HALL ROAD LEONARD TOWN MD. 20627 32. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 1 1 2008

KODALI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			State of Maryland / Dep	partment of Health and Men	ntal Hygier	1e
			1 - State Registrar C6	ertificate of Death	Reg. N	No.2008 27225
	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year 3. Time of Death
	/Medic	al	Robert Jack Doran, Sr.  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	ıg. 4,	2008   11:08p M
	Examin	er	Southern Maryland Hospital	Clinton		Prince George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		578-42-1186   ¹\X\M 2□F   78 Yrs.		3/11/19	
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	Location		10d. Inside City Limits
	Maryl Fish	tor	MD Pr. George's	Clinton		1 <b>X</b> Yes 2 □ No
	or 283	Director	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Country?
	23a c	ral	7716 Woodyard Road	20735		USA
	er deg	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Specify) If Yes, specify Cuban, Mexican, Puerto Rical	Yes or No- an, etc.)	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>
330	172 hours after death with the Maryland "natural", or items 23a or 28a-f show walkal Eval. if at rough be notified at	by F	1 □ Never Married 2 □ Married 1 ▼ Nes 2 □ No If Yes, Give Year or Dates: 51-55	1 ☐Yes 2 <b>X</b> No Specify:		Specify: White
2-003p	2 hou	ted	15 Decedent's Education 16a, Dec	edent's Usual Occupation	16b.	Kind of Business/Industry
V		Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	re kind of work done during most of working DO NOT use retired)		
7	e filed within al Hygiene. other than ' vent, tre inc	S	2 Gas  17. Father's Name (First, Middle, Last)	Station Attendant  18. Mother's Name (Fin		s Station
all	d be f ental ked o	To Be	William Clark Doran	Donna Gou	_	sir ourname,
	s 1 and 2 should be filed if Health and Mental Hyg item 27 is marked othe other traumatic event,	ř		ling Address (Street and Number or Rural Ro		y or Town, State, Zip Code)
Ξ	1 and 2 Health a em 27 is		I	Box 1056, Waldorf	, MD 20	0604
OLE	ges 1 If iter or oth		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State	position (Name of Date ematory or other place)		Location - City or Town, State
altimo	it. Pa rtmen rtant: njury	19	4☐Donation 5☐Other (Specify) Chelte:	nham Vets   8/12/0		eltenham, MD
ם מ	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.			<sup>22. Name and Address of Facility</sup> Rayr PO Box 430, Dunkii		ood F.H., P.A. 20754
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.			Approximate Interval Between
31.	Physician	ľ	Immediate Cause (Final disease or condition	atro Cardio VI	3 cales	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	R. Plan		
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ב ב	he lav e has ige 2 s	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
9	an; T	Φ	25. Was case referred to predical	26. Place of Death (Ch	1 □Yes 2 □ heck only one)	1 ☐ Yes 2 ☐ No
>	hysici nis ce I direc	일	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	Other:		6 ☐ Other (Specify)
=	ing P		27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time Injury	Work?	Describe how in	jury occurred
2	ttend death stor: / the f	icati	□ Accident investigation  3 □ Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, s	M 1 Yes 2 No	Lanation (Cture)	and Alumbau as Rural Revita Alumbau
2	al or A after Direct d in by	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and dinvestigation, in my opinion, death occurred at	due to the cause at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To th Withir Comp	Me	29b. Signature and title of certifier HVU 5100 YOLAA	29c. License number	29d. [	Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type	50454 Sul 235 Cl	170	MO 2078 -
	Sta	te	31. Date filed (Worth, Day Cear) 32. Registrar's Signature	Sur - SS Cl	10.5	7. 10 - 700
	Registra		AUG 7 2008 Beaut & Sparts	٤		

State

31. Date filed (Month, Day, Year)

AUG\_0 8 2008

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0623 M HELEN 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Hospice of the Chesapeake Anne Arundel Harwood If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 M 2 5 F 219-48-4813 Yrs. 61 13, 1946 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Prince George's Hvattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2408 57th Avenue 20785 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify Specify White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 10 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carmelo Garofolo, Sr. Ethel Lorraine Flaherty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Wayne DePriest - Husband 2408 57th Avenue, Hyattsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 8/12/2008 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a-Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) oncrear Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was an autopsy performed?
Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Nother (Specify 1 Yes 2 No 1 | Inpatient 3□ DOA 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760.

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examiner must be notified at

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Baltimore, Maryland 21215-0036

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4 Homicide

(Check only one)

29b. Signature and title of oprtifi

29a. Certifier

and manner stated

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

who completed cause of death (Item 23a) (Type, Print) Name and address of person

DEFENSE

CN d (Month, Day, Year) G 1 1 2008 32. Registrar's Signatu

determined

			For State Registrar	State o	f Marylar	nd / Depa <i>Cei</i>			lealth a Death		ental Hy	giene Reg. No.	ZIIII	27	228
7			Decedent's Name (First, Midd	le, Last)							2. Date of De			3. Time of	Death
	Physici /Medi		Dora Mae Dalt	on								7, 2	2008	9:35	рм
	Examir	ner	4a. Facility Name (If not institution	. 0	nber)				Location o				County of Death		
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ш	Funeral Director		217-32-1475	1□M 2⊠F	7. Age (117)13	1/	Months		Hours	Min.	(Month, Di	ay, Year)		place (State on try) ricksbur	
2.	D		Usual Residence of Decedent								4/23/	1933			
	ırylan show	b	10a. State 10b. County	′	10c. C	ity, Town or Lo	cation							10d. Inside C	*
	he Ma Ba-f s	<b>Funeral Director</b>		e George's	5	Hyatt									2 🔀 No
	with the	D.	10e. Street and Number				10f. Zij	p Code					zen of What Cou	intry?	
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Maryland	2 sho and Ism		19a. Informant's Name/Relations				-						r Town, State, Zi	ip Code)	
	1 and 2 Health em 27 l		Miles W. Daltor 20a. Method of Disposition	, Husband	20h	6926 Place of Dispo			Dr.,		tsvill ate		D 20784 ocation - City or T	Town State	
Baltimore,	permit. Pages Department of H Important: If ite any Injury or of		1 ☐ Burial 2 🖾 Cremation		State	cemetery, cre	matory or	other plac	´ i						. •
Ħ	artme ortani Injury		4 □ Donation 5 □ Other (3 21. Signar@re of Funeral Service		Me				atory ss of Facilit		1/2008		andria, 19 Balti		
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Вох	The law requires that the death certificate be executed the has I een signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come pf pregr		Testania -						23d. Date of deliv	very	
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TO			Of Was are referred to seed in								1□ Yes	2 X No	1 ☐ Yes	2 <b>K</b> No	
or Vital		o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☒ No	Hospital:	npatient 2	 ] ER/Outpatier	* 3 T D	Oth Oth	or.		(Check only		а Пон <i>(</i> 0	· · · · · · · · · · · · · · · · · · ·	
0	두 등 등	7: To	27. Manner of Death	28a. Date	of Injury	28b. Time o		28c. Injur Worl			ne 5 🔉 Hes 28d. Describe		6 □Other (Spec ry occurred	erry)	
ion	Attending F r death. ector: After by the funer	atio	1 Accident 5 Pendi 2 Accident invest	ng ( <i>Mon</i> a igation	h, Day Year)	Injury	м		k? Yes 2∐	No					
Division	or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	nined   286. Place	of injury - At h	nome, farm, sti	eet, facto	ry, office		2	8f. Location (	Street an	nd Number or Rui	ral Route Nun	nber,
	Ital or A rs after ral Directed in by	Cer													
	Hosp 4 hou Fune tely fil	ical	(Check only 2 Medica	ng Physician: To the I Examiner: On the b	asis of examin	iowledge, deat nation and/or in	h occurred vestigatio	d at the tir n, in my o	me, date ar pinion, dea	nd place, a ath occurr	and due to the ed at the time	cause(s) , date and	) and manner as d place, and due	stated. to the cause(	s)
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical	29b. Signature and title of certific	and man	ner stated.		29	c. Licens	e number		·	29d. Dat	te signed (Month	Day Year	
	F 3 F 8		> //// /w	nin	un 1			D087					/8/2008	, 20, 1001)	
	1 (10)		30. Name and a dress of person	who conclete caus	e of death (Ite	m 23a) (Type,	Print)	וסטע	J+		-	0	7072000		
1	-0		Thomas A. Bens			Greenw	,	tr Di	., G1	reenb	elt, M	D 2	0770		
v	Sta	ite	31. Date filed (Month, Day, Year	) <u>a</u> 32. R	egistrar's Sigr	nature									
	Regist	rar	AUG 1 1 2008	Realer	N 4	1000									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AMonth Hugust Physician Frances Kaye Duncan /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) Aug. 10, 1938 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Sex 1□M 2ÅF Hours Days Min. Months 220-34-7783 69 Aug. Alabama Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be motified at 1 Tyes 2 No Director Smithsburg Washington County 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 15 W. Water St. 21783 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No White 3altimore, Maryland 21215-0036 Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Company Real Estate Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kimbell Johnson Mary Hill McGilvray Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 is r permit. Pages 1 and Department of Health Important; If item 27 any Injury or other thorone. W. Water St. Smithsburg, MD 21783 Kenneth Duncan-husband 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 8-11-2008 Smithsburg, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, and implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a const uence of): **Physician** achi disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy

☐ Live birth 2☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year Pregnant at time of death 5 Other (specify) 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2X ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident investigation the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Drown B DOOS 7600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22911 Jeffren Blod Snimby MD 21753 31. Date filed (Month, Day, Year) State AUG 1 3 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2008 0530 Charles Degen August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dicomico Rehaby Nursing Ctr. ISBUTU lisburu  $\Sigma$ If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. tast birthday) 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1⊠M 2□F Yrs. Director 220-34-3689 9-20-1936 West Virginia Usual Residence of Decedent регтіt. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10a, State 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2X No Director Wicomico Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 30075 Haymarket Court Funeral 21804 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes Z∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2X Married ō Maryland 21215-0036 1 ☐ Yes 2/☐ No Specify: Specify: þ White 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Construction Important: If Item 27 is marked other any Injury or other traumatic event, Il once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Degen Laura Leigh Klingenfelter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline M. Degen - Wife 30075 Haymarket Court, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Crematory of Delmarva 8-8-2008 Delmar, Delaware 22. Name and Address of Facility Bounds Funeral Home MUSE 705 E. Main Street, Salisbury, MD 21804 23a. Part1. Enter the disease, or confidential that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) e.a. /Medical Due to (or as a consequence of): Examiner 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CA Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2☐No 3☐ Probably 4☐Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy certificate ha performed' 2 10 No 1☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 4 No ၉ 1 Inpatient 2 ER/Outpatient 3□ DOA s after death.

I Director: After this of in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. Jilliam H. 200 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 1 2

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** August 10, 2008 5:50 P.M Edgar Dianne Lee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel South River Health & Rehabilitation Edgewater If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) 06/12/1938 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☑ F Director 217-34-7834 70 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 🕅 No Funeral Director Calvert Lusby 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 11340 Mesquite Lane 20657 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: white Completed by 3 ☐ Widowed 4 ☑ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Knorr ပ္ George Rittler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11340 Mesquite Lane, Lusby, Maryland 20657 Victoria L. Embrey (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematory 8/11/08 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ucensee Rausch Funeral Home, P.A. 22. Name and Address of Facility P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) therosclerotic Carolio Vancular diseoso **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown insulficien of 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Dementio 24a. Was an autopsy performed? Yes 2.00 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide Hospital 29a, Certifier 1 Yertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier eyen.c. Surano 50653 ayon c Surona 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dew lo 851 Deall 31. Date filed (Month, Day, Year) 32. Registra & Signature State 12 AUG 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Tyrone Fitzhugh August 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rehab Fort Washington p If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Fort Washington Health & Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Prince Georges

9. Birthplace (State or Foreign Country) **Funeral** 1 3 M 2 □ F Director March 30,1954 Wash., DC 579-72-4072 Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or itame 23a or 28a-f ahow any injury or other treumatic avant, the Medical Examinar must be notified at ange. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 TXYes 2 □ No by Funeral Director Md. PGSuitland 10g. Citizen of What Country? 10e, Street and Number 3711 Deming Drive 20746 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 22 No If Yes, Give Year or Dates: Black, White, etc. 1√2 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ( Mary C. Smith Howard C. Fitzhugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 37.11 Deming Drive
Still and MD. 20746

20b. Place of Disposition (Name of cemetery, crematory or other place)

8/22/0 Pamela Smith/sister 20a. Method of Disposition 8/22/08 1 TBurial 2 Cremation 3 Removal from State Waldorf, Md. 4 ☐ Donation 5 ☐ Other (Specify) Heritage Mem Cemetery 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Hdvanced Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Completed by Physician/Medical Examiner ig physicien and as the burial-transit Hospitel or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Disease Mellitis 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24e. Was an 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending investigation 1 ZNatural 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: All completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008 2, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Her Ju 1201 do

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 egistrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Alice Fletcher Freymann 9, 2008 7:00 A Aug. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Collington Episcopal Life Care Mitchellville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 🖸 F 118-22-8562 Director 80 21, New York Feb. Usual Residence of Decedent 10b. Counts 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at 1 ☐Yes 2 🕅 No Director Marvland Prince George's Mitchellville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10450 Lottsford Road, #3-04 20721 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. filed within 72 hours after 1 ☐Yes 2 XNo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify þ Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any Injury or other traumatic event and once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Saxton Woodbury Fletcher Louise Kitchell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10450 Lottsford Rd., #235, Mitchellville, MD 20721 Jarvis M. Freymann - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Metropolitan Crematory 8/11/08 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Dec Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) emenia MONS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Exam and Due to (or as a consequence of) Box 68760, attending physician for use as the buria certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No P.O. the 9 I Unknown 9 Unknown Š signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 2 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ №0 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral c 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie (Type, Print) R, 1 1, 1/2 Rd A 3) 2 BUNIE MD 2071

State Registrar

4000 1adel 32. Registrar's Signatu 31. Date filed (Month, Day, Year) AUG 1 1 2008

30. Name and of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1420 DM Elizabeth Alverdia Finlayson August 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mentgemeru Montgomery Olnu treneral Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 ☐ F 76 577-40-3671 **Director** December 4, 1931 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be natified at appear. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code 20906 3203 Hewitt Avenue, Apt. 104 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 ∐Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Montgomery County Government 12 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John David Rees Frances Alverdia Glotflety ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra J. Rees / Sister 21704 8103 Canterbury Drive, Frederick, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) August 7, Alexandria, VA Metropolitan Crematory 2008 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Peritoritis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Pulmenary physician and s the burial-tran embalis Due to (or as a consequence of): Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒No 24a Was an cate has I page 2 s autopsy certificate 2 **N**O 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760 Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

Elizabeth

Baltimore, Maryland 21215-0036

Medical

State

Registrar

29a. Certifier

31. Date filed (Month, Day, Year)

AUG

29b. Signature and title of gertifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101

and manner stated.

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Registrar's Signature

			For State Registrar	State of	f Marylan		artment of H				giene Reg. No. 2	008	27236
	Physici		1. Decedent's Name (First, Middle Emma M. Forema							Date of Dea Month	Day	Year 2008	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution Atlantic General	on, give street and nun			4b. City, Town, or Berlin	Location		.ug	4c. Coun	nty of Death	
20	Funeral Director		5. Social Security Number 213–22–7204	6. Sex 1 □ M 2 □ F	7. Age (In yrs. 79	las <i>t birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day	1929	9. Birthi Coul	place (State or Foreign ntry) MD
FI 3	death with the Maryland ims 23a or 28a-f show	tor	Usual Residence of Decedent  10a. State 10b. Count  MID Wor	cester		y, Town or Lo	ocation					1	10d. Inside City Limits
100	with the a or 28s	Direc	10e. Street and Number				10f. Zip Code 21811				10g. Citizen o		ntry?
slos	_ in # ₹	by Funeral Director	11.3 Flower St.  11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 Divorce	rried Armed For	2 🔀 No		Was Decedent of H If Yes, specify Cuba 1 □Yes 2√√2 No	lispanic Or an, Mexica Specify		fy Yes or No- can, etc.)	14. R	USA ace - Americ lack, White, pity: 181a	etc.
DOD: 8/8/	Dallillofe, Mary Jialio ZIZIS-UUSO permit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hyghene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Exert page.	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	nt's Education est grade completed)  College (1	-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done o DO NOT use retired	during mos d)	st of working		16b. Kind of	Business/In	dustry
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Sol	Dealth permit Departm Importa any inju		21. Signature of Funeral Service			1	2. Name and Addre CWIS N. V 618 West	ss of Facili	ity n Fune	eral Ho	ome		
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	P														
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E	Physici /Medic		1. Decement's Name (First, Middle, Last,					2. Date of De Month	Day	2008 8:45 A M
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	ne Marylar 8a-f show	Director	10a. State 10b. County		es ter	nwest				10d. Inside City Limits 1   Yes 2  No
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21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Madical Exterill at the tall had all	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occ kind of work dor DO NOT use reti	ne during most o ired)	f working		Business/Industry
and 5	be filed tal Hygi d other event, I	To Be Co	17. Father's Name (First, Middle, Last)  Daniel Graves		TACTO	ey woe	18. Mother's	Name (First, Middle	, Maiden Suma	ell Soup Inc.
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Baltimore,	Page ment o ant; If ury or		20a. Method of Disposition  1 Separation 2 Cremation 3 F  4 Denation 5 Other (Specify)	20b. P	tace of Dispo emetery, cred UCHRIST	osition (Name of matory or other p	place)	Date - 16-2008	20c. Location	- City or Town, State
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		4	For State amend #5 Per	State of Marylan	id / Depa 27 / 08: al	artment of H	lealth and M Death	lental Hyg	iene <sub>eg. No.</sub> 2008	27239
	-		Registrar  1. Decedent's Name (First, Middle, Last)	1111 0002 072		tille of t	Jean	2. Date of Dear	th	3. Time of Death
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	/Medic		Patricia Kenned			4b. City, Town, or	Location of Death	nug. J	4c. County of Dea	th
	Examin	er	, , , , , , , , , , , , , , , , , , , ,			Bethes	da		Montgom	ery
	Funeral		5406 Spangler 5. So <b>537 Georg Oling Go 7</b> 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bir	thplace (State or Foreign ountry)
и	Director		<del>577-40-8643</del> 1 <sup>1</sup>	M 212 F	Yrs.	IVIOIIIIIS Days	TIOUIS INIII.			ryland
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	vith th		10e. Street and Number				,			ŕ
	s 23a	eral	5406 Spangler Ave	2. Was Decedent Ever in U	1 S 13.	2081 Was Decedent of H	. <b>b</b> Iispanic Origin? (Sr	ecify Yes or No-	U.S.A 14. Race · Am	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 Amarried  3 □ Widowed 4 □ Divorced	Armed Forces?  1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:	,	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an, Mexican, Puerto Specify:	Rićan, etc.)		<sub>te, etc.</sub> W <b>hite</b>
Ö	hour tural	pa pa	15. Decedent's Educ		16a. Dece	dent's Usual Occup	ation		16b. Kind of Business	s/Industry
ξ	in 72 " ra ledic	Completed	(Specify only highest grade	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wor d)	king		
7	jene.	E	Elementary/Secondary (0-12)	_2		Homemake	r		Own Hom	e
b	other ent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Surname)	
<u>a</u>	ould be filed w I Mental Hygie harked other t hatlc event, th	10 E	John Kennedy					Cecelia		
ary	shool and for		19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mail	ing Address (Street	and Number or Ru	ral Route Numbe	er, City or Town, State,	Zip Code)
Σ	and 2 saith n 27 I		Laura Garrabrant		Bet	6 Spangle hesda, Ma	ryland	20816 Date	20c. Location - City of	r Town State
ore	es 1 of He fiten		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re		Place of Disp cemetery, cre letropo	osition (Name of ematory or other pla			20c. Location - City o	r rown, State
<u>Ĕ</u>	Pag ment ant: I ury o		4 □ Donation 5 □ Other (Specify)		remato	ry				, Virginia
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra		21. Signature of Funeral Service Ucense	Ful	2		nsin Ave	N.W.,		D.C. 20007
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the dea e cause on each line.	ath. Do not er	nter the mode of dyi	ng, such as cardiad	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
	Physician	1	Immediate Cause (Final disease or condition		assula	1 Acciden	it			Olisot and Doddi
	/Medical	П	resulting in death)	Due to (or as a conse	quence of):					
	Examiner		Sequentially list conditions, b	Atrial		lation				Months
	D #	ine	ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consu	/					Years
	cate be executed physician and the burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a conse	equence of):			<del></del>		10013
8760,	be ex cian burial	三田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田			,					
387	icate physi	dical	d							
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown	3c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	□Ectopic pregnand □ Other (specify) _	sy		23d. Date of o Month	lelivery Day Year
P.O.	hat th rd by detacl		Part II. Other significant conditions cor	tributing to death but not re	esulting in the	underlying cause gi	ven in Part I.	23e. Did t	obacco use contribute	to the cause of death?
or Vital Records,	uires tha signed I	d by						1 🗆	Yes 2√ No 3□	Probably 4 ☐Unknown
202	w require been si should b	Completed						24a. Was		autopsy findings available to completion of cause of
Re	he la s has ige 2	m d						auto perfo 1⊟ Yes	ormed3 death	?
ā	ificate or, pa		25. Was case referred to medical				26. Place of De	ath (Check only o		
Ë	Physiclan: The law this certificate has I ral director, page 2 s	o Be	evaminer?	lospital: 1 ☐ Inpatient 2	☐ ER/Outpati	ent 3 DOA O	ther: 4 \( \sum \) Nursing I	Home 5 Resi	idence 6 ☐Other (S	pecify)
o	- E	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time		ury at	28d. Describe	how injury occurred	
ion	Attending F r death. ector: After by the funer	atio	1 Matural 5 Pending 2 Accident investigation	(World, Day Tour)	,,		]Yes 2 □ No			
Division	l or Atte after des Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At building, etc. (Spe	home, farm, s	street, factory, office		28f. Location ( City or To	(Street and Number or wn, State)	Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Exami	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, de ination and/or	ath occurred at the investigation, in my	time, date and place opinion, death occ	e, and due to the curred at the time	e cause(s) and manner , date and place, and	as stated. due to the cause(s)
	o the ithin o	Me	29b. Signature and title of certifier				nse number		29d. Date signed (Me	onth, Day, Year)
			Cynthia J. Lee	, De		Ho	057898	¢	8/06/08	
	20		30. Name and address of person who co	ompleted cause of death (If	tem 23a) (Typ		thia J. I			
		tate	31. Date filed (Month, Day, Year)  ALIG 0 8 2008	• ,	-	rette 0				
	Regist	u dil	MIR- 0 0 /1118	ATRING LR J OK	I' ASTER	THE COLUMN THE PERSON NAMED IN COLUMN THE PERSON				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** August ne Dawn 2008 1:05 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Berlin Nursino Berlin larcester Hong . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗹 F Months Days Hours 234-30-9673 Director 3/1925 West Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heatilt and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner. cean Ci 1 Yes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21843 1801 Atlantic Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Gray June Baltimofe, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NIA 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be hester Bodiner Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John 706 N. Oakland Arlington, VA 22203 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 8/11/08 Dover, DE Direct Cremation, LLC 4 Donation 5 Other (Specify) of Foneral Service Licens 22. Name and Address of Facility 917 W Isabella St. MD 21801 Bennie Smith Funeral Home or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset end Death 23a. Part1. Enter shock, or he r the disease Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Grand Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attendential 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

YOCESH

31. Date filed (Mooth La

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 614

2008

EASTERN

legistrar's Signature

VOHLA

D 63199

DX

			- FOI	epartment of Health and Mental  Certificate of Death	_
	Physici		1. Decedent's Name (First, Middle, Last) Lloyd Raymond Harris	2. Date of Month Augu	
4	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death  Leonardtown	4c. County of Death St. Mary's
	Funeral Director		St. Mary's Nursing Center  5. Social Security Number  6. Sex  7. Age (In yrs. last birth.  1 ☑ M 2 ☐ F  97 Yi	day) If Under 1 Year   If Under 24 Hrs.   8 Date of	
	e Maryland Ba-f show	ector	Usual Residence of Decedent  10a. State  Maryland  St. Mary's	California	10d. Inside City Limit
	th with th	Funeral Director	23254 Chestnut Oak Court Unit 100	10f. Zip Code 20619	10g. Citizen of What Country? USA
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Mcdical Evantina roust be notified at		11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 ☒ Yes 2 □ No  If Yes, Give  Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:	or No- 14. Race - American Indian, Black, White, etc.  Specify: White
21215-0	I within 72 ho giene. <b>r than "natu</b> i	Completed by	(Specify only highest grade completed) (Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Operty Manager	US Government
Maryland 2	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Mental than aumatic event, the Mental than an aumatic event, the Mental than a manatic event than the Mental than the Men	To Be C	17. Father's Name (First, Middle, Last) Howard M. Harris	18. Mother's Name (First, M Frankie Le	
Mar	d 2 sho Ith and I7 is ma traum			Mailing Address (Street and Number or Rural Route No. Box 1308 Mechanicsv	
altimore,	Pages 1 and 2 nent of Health int: If item 27 i iry or other tra		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of I cemetery,	Sisposition (Name of crematory or other place) Memorial Gardens  August 15, 2008	20c. Location - City or Town, State
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee Jandense	22. Name and Address of Facility Mattingley-Gardiner Funera P.O. Box 270 Leonardtown,	1 Home, P.A. MD 20650
760,	Physician / Medical Examine physician and physician and the pnirel-transit the pnirel-transit physician and physician and physician and physician and physician and physician are provided by the physician and physician are provided by the physician and physician are provided by the physician are provided b	dical Examiner	23a. Part 1 Enter the disease, or complications that caused the death. Do no shoot, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of d.	ry Artery Dis	Approximate Interval Between Onset and Death Survey
.O. Box 68	the death certificate y the attending physiched for use as the t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery  Month Day Year
rds, P.	faw requires that the das been signed by the 2 should be detached	b	Part II. Other significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions.	the underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
al Reco	The fa ate has bage 2	Completed	rostatio Jepartrophy-l	200 to the total of	Was an autopsy findings availab prior to completion of cause of death?  Yes 2♣No 1 ☐ Yes 2 ☐ No
Division of Vital Records,	ing Phys n. After this funeral di	Certification: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined  4 Homicide  2 ER/Out  28a. Date of Injury (Month, Day, Year)  Injury Sear Place of Injury - At home, farr building, etc. (Specify)	me of ury 28c. Injury at Work? 28d. Des Work? 1 Tyes 2 No 28f. Loca	nonly one)  Residence 6 □Other (Specify)  pribe how injury occurred  tion (Street and Number or Rural Route Number, or Town, State)
	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Medical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and mannyr stated.		
	To th withir To th	Me	29b. Signature and title of certifier  Something for the signature and title of certifier  And the signature and title of certifier	29c. License number  D 06419	29d. Date signed (Month, Day, Year)
_			30. Name and address of person who completed cluse of death (Item 23a) (1 24035 Three Notch Road Hollywood		oe, M.D.
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 1 3 2008		

Division or Vital Records, P.O. Box 68760, this

ို Certification:

within 24 hours a

State

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

2 Accident

3□ Suicide

29a. Certifier

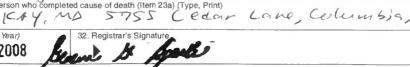
Medical

4 Homicide

(Check only

1 Natural

AUG 0 8 2008



2322

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

5 Pending investigation

6 Could not be

[Cendralcan

determined

1 Thipatient

(Month, Day Year)

28a. Date of Injury

2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 Yes 2 No

D0062545

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year August 2008 Virginia Miller Pearl Hoffman 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2XXF Months Days Hours 96 June 24,1912 Maryland 219-14-8339 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes XIX No <u>Maryland</u> Washington Williamsport 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 16382 Spielman Road 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ※XXNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XX No Specify. Specify. 3€Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Laborer Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cunningham William <u>Annie</u> Metz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16044 Natural Well Rd. Williamsport, Maryland 21795 Darlene Stotler - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) Greenlawn Mem. Park |Aug.14,2008|Williamsport, Maryland 4 ☐ Donation 21. Signature of Fune OSBOTATE AFTINETE TO HOME, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INSUFFICICAC RENAL disease or condition resulting in death) Due to (or as a consequence of): LEUKOCYTOGI Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HYPERKALAW Due to (or as a consequence of): DENENTIA IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🖸 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2. ENO 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician /Medical Examiner

Department of Health a Important: # Item 27 is any injury or other trainonce.

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be ပ

**Funeral** 

Director

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show

Maryland 21215-0036

altimore,

P.O. Box 68760,

Pages 1

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, its the lifett Examination must be notified at

• Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• La hours after death.
• Funeral Director. After this certificate has been signed by the attending physician and elely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/Medical Completed Be Certification: To

Division of Vital Records, within 2

13H-2

State Registrar

Medical

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12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

OL S. AZIZ, MD

East Antietan St, Hageistown

13 2008

29a. Certifier

(Check only one)

29b. Signature and title of certifier

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 10 11:39 A<sup>M</sup> 2008 Brenda Marie Hall 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Ocean City Worcester 205 143rd St. 8. Date of Birth (Month, Day, Ye 9/8/1952 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1 ☐ M 2 🛣 F Washington DC 55 219-58-8999 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Worcester Ocean City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21842 USA 205 143rd St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2K No Specify: Specify. white 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Defense Contract Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louise Beavers George Tilch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 205 143rd St., Ocean City, MD 21842 Raymond L. Hall / husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/11/2008 Cape Henlopen Crem. Frankford, DE 4 □ Donation 5 □ Other (Specify) 21. Signature o Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastutic Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 🗷 No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2☐ No 1∐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner Examiner the death certificate be executed

**Physician** 

/Medical

Examiner

Director

Completed by Funeral

Be 107

**Funeral** 

Director

the Maryland or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mentia Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician/Medical

the attending physician and hed for use as the burial-tran detached To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Completed

Be

2

Certification:

Medical

State

Registrar

Division or Vital Records, P.O. Box 68760.

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death 1 Natural

5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

M.D.

030690

Aug. 11,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m. D. 145 E. Gerall St., S.1.36007, MO 21801 MARTIN

31. Date filed (Month AUG 2008 32. Registrar's Signature

25

8-06276	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.								
theryl A. Hansen Jo	State of Maryland / Department of Health and Mental Hygiene Certificate of Death  Reg. No. 2008 272								
	strar 2 Date of Death 3. Time of Death								
Physician/ Medical Examiner	Cheryl Appa Hansen Jones August 16, 2008 1102 110								
E	Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Calvert								
C	2499 Chaneyville Road Owings								
Funeral	Months Days Hours Min. 12/21/1056 Country) Georgia								
Director	219-76-4561 1 M 2XF 31 Yrs. 1 12, 27, 23, 24								
any	Jal Residence of Decedent  10d. Inside City Limits  3. State 10b. County 10c. City, Town or Location								
<b>3</b>	MD Calvert Owings								
the Maryland a or 28a-f show lifted at once.  Director	e. Street and Number								
the M tiffed Dire	2499 Chaneyville Road 20736 U.S.A.  14. Race - American Indian, Black,								
death with tritems 233 nust be not	Married 12. Was Decedent Ever in U.S.    Married   12. Was Decedent Ever in U.S.   13. Was Decedent of Hispanic Origin? (Specify Yes or No-   If Yes, specify Cuban, Mexican, Puerto Rican, etc.)   14. Race - American Indian, Black, White, etc.   14. Race - American Indian, Black, White, etc.   15. Was Decedent Ever in U.S.   16. Race - American Indian, Black, White, etc.   17. Was Decedent Ever in U.S.   18. Was Decedent Ever in U.S.   18. Was Decedent Ever in U.S.   19. Was								
or ite	1 Yes 2 X No Specify: Specify: White								
aral",	whowed or Dates: 16b, Kind of Business/Industry								
2 hour "nate	Flementary/Secondary (0-12) College (1-4 or 5+)								
5-0036 ed within 72 hours tygiene. other than "natu he Medical Exan	12 welder pile drivers union  18. Mother's Name (First, Middle, Maiden Surname)								
5-0 Hygie I other	Father's Name (First, Middle, Last)								
121 d be fill fental I farked event,	Frederik August Hansen Beryt Jane Rett  a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Hand Mental Hygiene. Important S7 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	David H. Jones, husband 2499 Chaneyville Road, Owings, MD 20736								
and 2 Jealth Titem 2	Date 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City of Town, State								
TOT6 ages 1 nt of F	So. Memorial Gardens   08/23/2008   Dunkirk, MD								
altin nit. P sartme sortar ury or	22. Name and Address of Facility Rausch Funeral Home, P.A.								
P. P. P. Light	Syan & Mullaceth 8325 Mt. Harmony Lane, Owings, MD 20736  Approximate Interva								
Physician	Approximate Interval Sa. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. See only one cause on each line.  Approximate Interval Between Onset and Death								
Medical aminer	mmediate Cause (Final disease a. Cardiac arrhythmia roondition resulting in death)  Due to (or as a consequence of):								
-	b								
Sequentially list conditions, if any, leading to immediate cause. Each Inderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
	Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
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68760, certificate be ding physic	F FEMALE: 23c. If yes, outcome of pregnancy Month Day Year								
AMENDED 23a, PII, 27, perME, g883 9/16/08 TT    Variable   Variabl									
the death c the death c by the atten	1 Yes 2 No 9 V Unknown g Unknown  g Unknown  23e. Did tobacco use contribute to the cause of death?  contributing to death but not resulting in the underlying cause given in Part I.								
ed by	1 Yes 2 No 3 Probably 4 V Unknown								
Fatty liver; chronic alcoholism; malnutrition  1  Yes 2 No 3 Flows  24a. Was an autopsy prior to co									
paralysis due to spinal disease death?									
tal Rec	20 Death (Cheate only age)								
Vital ysician: his certil director	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other: Scene								
of Vii	27. Manner of Death  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?  28d. Describe how injury occurred								
ion C tending eath. tor: Af	1 X Natural 5 Pending								
Division fall or Attendiurs after death.	2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Cor Town, State)								
Division o  To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	determined (Specify)								
e Hos n 24 h re Fun letely	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
To the Ho within 24 To the Fu complete!	and manner stated.  29c. License number  29d. Date signed (Month, Day, Year)								
	O.C.M.E. August 17, 2008								
	30. Name and address of person who completed cause of death (Item 23a)								
	Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
Sta	31. Date filed (Month, Day, Year)  32. Registrar's Signature								
Regist	AUG 1 9 2008 Seek, If April ORIGINAL OCME								
DHMH 17 Rev 1/20	ORIGINAL								

			For State Registrar	State of Marylan	•	rtificate of I		Re	eg. No.ZUU8	27246
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Mary Eli		nnette		and the state of t	2. Date of Death Month August	Day Year 10 2008	3. Time of Death 11:50 P M
6	Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
1		6137 4th Street					eake Beach	Calvert	Calvert	
	Funeral		5. Social Security Number 6. Sex		last birthday)	double If Linder 1 Year   If Linder 24 Hrs   8 Date				
220	Director		213-88-1772	]м <sup>2</sup> Х	Yrs.	Months Days	Hours Will.	12-29-1	961 Mar	yland
	faryland show ed at	ō	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits							
	the N 28a-f	Director	MD Calvert  10e. Street and Number			Chesape 10f. Zip Code	eake Beacl		0g. Citizen of What Cou	
	a or							'		indy:
	be filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	era	6137 4th Street	12. Was Decedent Ever in U.	6 10 1	20732		oifu Vaa or Na	USA 14. Race - Ameri	can Indian
920		by Funeral	11. Marital Status  1   ↑ Never Married 2   → Married  3   → Widowed 4   → Divorced	Armed Forces?  1  Yes 2 No If Yes, Give		If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)	Black, White Specify:	
Ö		ted	15. Decedent's Edu	cation	16a. Deced	dent's Usual Occup	ation		16b. Kind of Business/le	
Maryland 21215-0036		To Be Completed	(Specify only highest grade Elementary/Secondary (0-12) 12	College (1-4or 5+)		kind of work done of DO NOT use retired	during most of worki i)	ng	food servi	i ca
22	e filed value of the vent, the		17. Father's Name (First, Middle, Last)			/OK	18. Mother's Name	(First, Middle, N		ice
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$\leq$	2 should be and Mental is marked canamatic even		19a. Informant's Name/Relationship (Ty		19b. Mailir	na Address (Street			; City or Town, State, Zi	
Ma	id 2 s ith an 27 is trau		Julia M. Jinnette		1				, MD 20732	p oode,
	Heal Heal tem 2		20a. Method of Disposition			sition (Name of matory or other place			20c. Location - City or T	own, State
no	ages ant of t: If it		1 N Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	temoval irom State I			ens   08-14	4-2008	Dunkirk,	MD
Baltimore,	nit. Faartme ortan injur		21. Signature of Funeral Service License							
B	permit. Pages 1 and 2 should be Department of Heath and Ments Important: If Item 27 is marked any injury or other traumatic enonce.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736							
498	Physician physician and physician and physician and physician and ss the burial-transit		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	ications that caused the deat ne cause on each line.	h. Do not ent	ter the mode of dyin	ig, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
			Immediate Cause (Final disease or condition	Ovaria	n Ca	Cancer (Metastatic).				
4			resulting in death)	Due to (or as a consequence of):						
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P.O. Box	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	ıl death 3 [	☐Ectopic pregnancy ☐ Other (specify)	4		23d. Date of deli	very Day Year
			Part II. Other significant conditions con		ulting in the u	nderlying cause giv	en i <b>n</b> Part I.		bacco use contribute to	_
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Ž	ys is dir	2	1 ☐ Yes 2 ☐ No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)						
n	To the Hospital or Attending Ph within 24 hours after death, To the Funeral Director: After th completely filled in by the funeral		27. Manner of Death 1 ■ Natural 5 ■ Pending					28d. Describe how injury occurred		
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_	Hospitai 14 hours a Funerai tely filled		29a. Certifier (Check only (Check only and manner as stated).  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)							
	To the I within 2, To the I complet		20h Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. Date signed (Montl	Day Voarl
	M. Wil		29b. Signature and title of certifier	zutD.			62123		290. Date signed (Month	
			30. Name and address of person who co	Ompleted cause of death (Iter	n 23a) (Tvne				-, -,	
<u>d</u> e	W 3		24035 THREE N	JOTCH ROA	D F	+OUY W	M Goor	D 500	636	
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 1	32. Registrates Signated 2 2008	ature	hours				

State of Maryland / Department of Health and Mental Hygien 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 3:30 PM Clifford Jones 8 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5310 Powellville Road Pittsville Wicomico If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F Director 214-28-1872 78 5-28-1930 Powellville Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits ir then "naturel", or Itema 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Directo Wicomico Pittsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5310 Powellville Road USA Funeral 21850 death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: White Be Completed by 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within ; h and Mental Hyglene. 7 Is marked other then \*r Elementary/Secondary (0-12) College (1-4or 5+) 11 Farmer Own Farmer traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental Important: If I sen 27 Is marked eny injury or other traumatic eventages. Roger Franklin Jones Delima Alice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy Donaway - Granddaughter 5384 Powellville Road, Pittsville, MD 21850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Riverside Cemetery 8-11-2008 Libertytown, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bounds Funeral Home Mison Day 705 E. Main Street, Salisbury, Maryland 21804 23a. Paul. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List any one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myelodysdustic Syndrome disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ipo Fibrinogen eula Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Turombocutopenia physicien and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical use as the IF FEMALE: NA 23c. If yes, outcome of pregnancy NA 23d. Date of delivery NIA 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Day Month 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Anemia Completed 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0066169 MD 08/08/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10445 ad Ocean City Blvd #1, Berlin, MD ZIBIN Angela Gibbs, MD 31. Date filed (Month, Day, Year) 32. Figistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-06203 State of Maryland / Department of Health and Mental Hygiene Robert Clifton Keedy, Jr. Certificate of Death Reg. No. Registrar 3. Tune of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 13, 2008 Year 1937 hrs **Medical Examiner** ROBERT CLIFTON KEEDY JR. c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 181 Washington Hagerstown Washington County Hosptial 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) funeral Hours Days Country) MARYLAND Director 1976 FEB. 10, 32 217-19-2192 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 X No MAUGANSVILLE Baltimore, MD 21215-0036 permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once. WASHINGTON MARYLAND Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21767 13840 MAUGANSVILLE ROAD 13. Was Decedent of Hispanic Ongin? (Specify Yes or No 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 X No Yes WHITE Specify: If Yes, Give Year Yes 2 X No specify Widowed Divorced à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) AUTO BODY REPAIR SANDER 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last SHARON ERMA FLOOK Be ROBERT CLIFTON KEEDY SR. (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19h Mailing Address 19a. Informant's Name/Relationship (Type, Print) ပ 13840 MAUGANSVILLE ROAD, MAUGANSVILLE, MD ROBERT C. KEEDY SR./FATHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Cremation 3 Removal from State 1 X Burial 8/18/2008 BOONSBORO, MARYLAND BOONSBORO CEMETERY Othe 22. Name and Address of Facility BAST-STAUFFER FUNERAL HOME ignature of Paul M. Dean 7606 Old National Pike, Boonsboro, MD or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval the disease **Physician** Between Onset and Death /Medical Heroin intoxication Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed sician/Medical AMENDED 23a, 27, 28a-f, perME, g882 8/28/08 TT X UNPENDED attending physician for use as the burial -Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Day Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Ph 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions ð No 3 Probably 4 V Unknown σ. Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? this certificate has No ✓ Yes 2 ✓ Yes 26.Place of Death (Check only one) 25. Was case referred to medical of Vital the Hospital or Attending Physician: Be Other4 Hospital: Residence 6 Inpatient 2 FR/Outpatient 3 Nursing Home 5 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 27. Manner of Death Certification: Yes 2X No unk Natural Division Pending death. Director: the 8/13/08 Fnd 6:30 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 17613 Gettysburg Way 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide Hagerstown, MĎ (Specify) found at friend's residence To the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie August 14, 2008 OCME My 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Tasha Greenberg MD. Assistant Medical Examiner strar's Signature 31. Date filed (Mo State

DHMH 17 Rev 1/2001

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DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** AUGUST Year 8 10:53AM Jean Bowers KEYSER /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F 218-10-1368 88 **Director** April 1,1920 Maryland Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 915 Kenly Avenue or items 23a 21740 USA Pages 1 and 2 should be filed within 72 hours after death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 ▼No If Yes, Give Year or Dates: Specify: þ white 3 X Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) school teacher county government Health and Mental Hygen 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wallace N. Wheatley 2 Ann Bowers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Selby - daughter 1204 Pinewood Dr., Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Mem. Park | 8/15/08 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licens MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CARDIOGENIC SHOCK Sequentially list conditions, if any, leading to infine flate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence off-Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of) Box 68760. CORONARY ARTERY DISEASE Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 D Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably DIABETES Completed 24b. Were autopsy findings available prior to completion of cause of death? RENAL INSUFFICIENCY 24a. Was an certificate has birector, page 2 s autopsy performed? (es 2 No 2 10 No 1 ☐ Yes 1 ☐ Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier

P.O. Division of Vital Records. 24 hours after deat Funeral Director: filled in

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 8-17-08 D31826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SH-10 31. Date filed (Month by Year) 32. Restrar's Signature 7601 OSLER DRIVE TOWSON, MARYLAND 21204 2008 State

Registrar

(Check only

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 10 Lloyd William Keller 2008 Рм 6:04 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Loyalton of Hagerstown Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 28,1920 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 220-05-6163 88 Maryland Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experience must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Washington County Hagerstown 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20009 Rosebank Way 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 2 □ Ne If Yes, Give Year or Dates: 4/1946 altimore, Maryland 21215-0036 1 □Yes 2 No White Specify <u>ک</u> Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Aviation Electrician Aircraft Manufacturer 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) William Calvin Keller Nellie Gaye Koogle Keller ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tra Helen Kepner-sister 1044 View St. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 8-14-2008 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. En line Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Ye ar Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 1 □Yes 2 □No s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has f funeral director, page 2 s 24a. Was an autopsy performed? Yes No 1 ☐Yes 2 ☐No 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1□ Yes No Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home Certification: To 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 🗆 Yes 3 Suicide 6 □ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

SH 15+1

31. Date filed (Month, Day, State Registrar

Year) AUG 1 3 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L/5a H/99 in 00 th cm mD ////0 K

29b. Signature and title of certifier



DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 30, 10:15 P<sup>M</sup> Kim Ju<sub>1</sub>y 2008 Jin Sung /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Randolph Hills Nursing Home Montgomery Wheaton If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🛛 F 579-70-2401 March 03, Japan Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2x No Directo Kensington Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10920 Connecticut Avenue #103 20895-1611 United States Funeral 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces?
1 ☐ Yes 2[X] No
If Yes, Give
Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0036 Specify. þ 3 ☐ Widowed 4 KI Divorced Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Child Care Sitter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20852 19a. Informant's Name/Relationship (Type. Print) 10717 Hampton Mill Terrace #210, N. Bethesda, MD Kim Kaplan / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page
Department of Important: If any injury or once. Ft. Lincoln Crematory 08/05/2008 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final 1½ years Pancreatic Cancer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of) KIM, JUNG J. Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 2 🔯 No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2K No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Injury 1 🛮 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0021033 August 4, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Byoung Lee, M.D. 13000 Georgia Ave. Silver Spring, MD 20906 31. Date filed (Month, Day, Year) 322Registrar's Signature State AUG 0 8 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup>2008 AUGUST 4, **Physician** 03:45A M LAMOTTE IV FERDINAND /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner KENT CHESTERTOWN CHESTERTOWN NURSING & REHAB Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2 □ F 72 2/18/1936 221-22-4979 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10h County 10c. City, Town or Location 10a. State 28a-f show Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Next in the 1 ☐ Yes 2 ☐ No Director ROCK HALL KENT MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21661 5802 WATERMANS WAY Funeral 14 Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 21 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) INVESTMENT FINANCIAL ANALYST 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JUNE MITCHELL FERDINAND LAMOTTE III ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5802 WATERMANS WAY ROCK HALL, MD 21661 DANIELLE LONDON/DAUGHTER 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION :8/5/2008 STEVENSVILLE, MD 22. Name and Address of Facility 21. Signat Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL 130 SPEER RD. CHESTERTOWN, MD 21620 leri 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of such line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical or as a consequence of) Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed burial-transi and Due to (or as a consequence of): Box 68760, physician Physician/Medical the. use as t attending r IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day for in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.O. the sate has been signed by page 2 should be detact 23e. Did tobacco use copyribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The 2 No certificate 1 □Yes 2 1 ☐ Yes 25. Was case referre examiner? medical funeral director, 26. Place eath (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖪 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Acciden within 24 hours after death To the Funeral Director: completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signati 2 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State AUG 0 8 2008 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician THELMA LOUISE LACKEY JUL 28 2008 4:00 P /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** 06/04/1934 Months Days Hours NorthCarolina 1□ M 2√ F 74 237-50-1298 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 INo Washington, D.C. Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number e filed within 72 hours after death with tall Hygiene. USA 20020 2822 Fort Baker Drive S.E. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ∑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Specify: Black 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: altimore, Maryland 21215-0036 Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic Home maker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f Pattie Johnson f Health and Menta item 27 is marked Buster Johnson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4801 Colorado Ave., NW. Wash., DC., 20011 Anita J. Herring/neice 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Department of Important: If ite 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/05/08 Riverdale, Md. Riverdale Park <sup>22. Name and Address of Facility</sup>B.K. Henry Funeral Home 420 H Street NE., Washington, DC. 20002 21. Signature of Funeral Service Licensee 420 H Street Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final **Physician** PULMONARY HYPERTENSION disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical as 1 attending properties for use as IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗓 No 4□Pregnant at time of death ached f 9□Unknown 9 DUnknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autonsy performed? 2**X** No certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 🔀 Inpatient P 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident

within 24 hours a To the Funeral I

ANDREW I. PHILIP 31. Date filed (Month, Day, Year) State AUG 1 1 2008 Registrar

3□ Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

6 Could not be determined



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

0101243094 (VA)

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

d in by the

Medical

			For State Registrar	State of Marylar	nd / Depa		Health and	Mental Hy	•	27251
*	Physici		Decedent's Name (First, Middle, La  Bernadette L					2. Date of De Month August	ath Day Year	3. Time of Death 8:30 a <sub>M</sub>
)	/Medic Examir		4a. Facility Name (If not institution, giv	e street and number)			, or Location of Dea		4c. County of Death	
	Funeral Director		Sacred Heart F. 5. Social Security Number 220-07-3957 Usual Residence of Decedent		. last birthday) Yrs.	If Under 1 Ye Months Day		n. (Month, Da	ly, Year) Cour	lace (State or Foreign
	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral Director	10a. State 10b. County	Georges  apel Road  12. Was Decedent Ever in U	ity, Town or Lo	7 <b>ille</b> 10f. Zip Cod	e <b>) 7 8 2</b> of Hispanic Origin? uban, Mexican, Pu		10g. Citizen of What Cour	
-0036	hours after d tural", or iten al Examiner	ed by Fun	1 X Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's E	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	16a, Dece	1 □ Yes 2 ☑ N	No Specify:		Black, White,  Specify: Whi  16b. Kind of Business/In	te
21215	d within 72 giene. er than "na , the Medic	Completed by	(Specify only highest gra	College (1-4or 5+)	(Give life.	kind of work do. DO NOT use ret Lvil Ser	ne during most of w ired)	rorking	U.S. Govern	,
Maryland 21215-0036	should be filed vind Mental Hygie marked other I umatic event, th	To Be (	17. Father's Name (First, Middle, Last  Joseph B. Lanal	nan , Sr.	40h Afaille	an Address (Ctr	Delia	a A. O'Ne		Octo
	1 and 2 sho Health and em 27 is ma ther trauma		19a. Informant's Name/Relationship ( Paul Lanahan S1 20a. Method of Disposition	c./ Nephew	6938	Conserv	ation Dr.		er, City or Town, State, Zip ield, Va.221 20c. Location - City or To	53
Baltimore,	t. Partmer		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Funeral Service Lice)		cemetery, cree cunt 01 emetery	isition (Name of matory or other) ivet		.11,08	Washington, neral Home	
Be	permi Depa Impo any Ir		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications t at caused the dea			consin Av	e. N. W.	Washington,	DC 20007 Approximate Interval Between Onset and Death
3760,	Physician /Medical Examiner per partial-transit per principle.	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Cardiopul Due to (or as a conse b. Atheroscl Due to (or as a conse c. Due to (or as a conse	quence of): erosis	Failur	e			
.O. Box 68	that the death certificate ed by the attending phys detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome pf pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	taIdeath 3□	⊒Ectopic pregna ⊒ Other <i>(specify</i>			23d. Date of deliv Month	ery Day Year
ords, P.	requires that the death een signed by the atter nould be detached for u	ted by Pł	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause	given in Part I.	23e. Did t	tobacco use contribute to t Yes 2 <sup>M</sup> No 3☐ Prol	he cause of death? pably 4 ∏Unknown
Vital Records,	an: The law lificate has b or, page 2 sh	e Completed by	25. Was case referred to medical				26 Place of D	24a. Was autol perfo	ormed? death? 2⊠ No 1 ☐ Yes	opsy findings available impletion of cause of
o	To the Hospitallor Attending Physician: The law requires tha within 24 hours after death.  To the Funeral Director: Affer this certificate has been signed completely filledlin by the funeral director, page 2 should be de	tion: To Be	examiner?  1  Yes 2 X No  27. Manner of Death  1 X Natural 5 Pending 2  Accident investigation	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. [	Othor:	Home 5 ☐ Resi	idence 6 Other (Special how injury occurred	(y)
Division	Hospital or Atter 24 hours - Iter deat Funeral Director itely filled in by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of injury - At h building, etc. (Spec	rify)			City or To		·
	To the Hosp within 24 hou To the Fune completely fil	Medical		nysician: To the best of my kn miner: On the basis of examin and manner stated.		vestigation, in n				o the cause(s)
	8		· demi			D5.	1520		August_6,_2	- ,
	Sta Regist		30. Name and address of person who  Bahram Pishdad,  31. Date filed (Month, Day, Year)  AUG 0 8 200	M.D., 1328 So	uthern		E., Wash	ington, I	D.C. 20032	

DHMH 17 Rev 1/2001

08-06124 Audie Lucas Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

udie Lucas		State of Mar I-For State	yland / Department of C <i>ertificate of</i>			No. 201	18 2725
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	Oortmodio or		Reg. 2. Date of Death		3. Time of Death
ledical Examir		Audie James Luca	as		Month D August 11, 2		0125 hrs
		4a. Facility Name (if not institution, give street and	d number)	b. City, Town, or Location of Death	1	4c. County of Death	1
		6500 Riggs Road		Adolphi Hyatts		Montgomery	thplace (State or Foreign
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs  Months Days Hours Mir	1.	Co	untry)
Director	ļ	579-92-0877 1X M 2	F 45 Yrs		Dec. 14	. 1962 Wa	shington, DC
any	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Locati	on			10d. Inside City Limits
* .		DG N/A	Washingt	on			1 X Yes 2 No
Maryland 28a-f show 1 at once.	5	DC N/A  10e. Street and Number	wasiiingt	10f. Zip Code	10g	Citizen of What Cou	ntry?
he Ma t or 2	Director	1112 Hamilton Street,	N F	20011		U.S.	
with as 23s		11. Marital Status 12. Was	Decedent Ever in U.S. 13. Wa	s Decedent of Hispanic Origin? ( S			ican Indian, Black,
death rriten nust l	Funeral	1 X Never Married 2 Married Arme	es 2 X No	es, specify Cuban, Mexican, Puerto	o Rican, etc.)	vvnite, etc.	
after al", o	ð.	3 Widowed 4 Divorced If Yes, Give or Dates:		Yes 2 X No specify:		Specify: Blac	
hours natur Exam		15. Decedent's Education (Specify only highest		it's Usual Occupation (Give kind of ost of working life. DO NOT use re		6b. Kind of Business/	Industry
36 thin 72 re. than "	ompleted	Elementary/Secondary (0-12) Collect		1		Non-Prof:	i+
5-0036 lled within 72 hours afte Hygiene. I other than "natural", the Medical Examiner	S	17. Father's Name (First, Middle, Last)	4 Couns		e (First, Middle, Ma		10
ID 21215-003 should be filed withing and Mental Hygiene. It is marked other the matic event, the Med	Be	James Russell Lucas		Audrey	Cecilia	Mayberry	
21 hould I and Mer is mar		19a. Informant's Name/Relationship (Type, Print		g Address (Street and Number or	Rural Route Numb	er, City or Town, State	
mad 2 should be fi and 2 should be fi fealth and Mental I tem 27 is marked traumatic event,		Sharon Lucas / Siste		Galloway St., N	.E. Washi	ngton, D.	C. 20011
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition  1 X Burial 2 Cremation 3 Remov		sition (Name of cemetery, her place)	Date	20c. Location - City or	Town, State
Page Page ment c		4 Donation 5 Other Specify:	Fort Linco	oln Cem. 8/		Brentwoo	
Baltimore, permit. Pages I ar Department of Hee Important: If ite Imjury or other tr		21. Signature of Funeral Service Licensee		Name and Address of Facility Mc			
	-	23a. Part I. Enter the disease, or complications the	at caused the death. Do not enter t	00 Georgia Ave.	, N.W. Wa	t. shock, or heart	Approximate Interval
Physician /Medical		failure. List only one cause on each line.					Between Onset and Death
kaminer			lications of gur as a consequence of):	isnot wounds			-
		Sequentially list conditions, b					
	ne	if any, leading to immediate Due to (or	as a consequence of):				
h	Examiner	(Disease or injury that initiated C.	as a consequence of):		•		<del>                                     </del>
cuted	٩	d					
tox 68760, eath certificate be executed attending physician and for use as the burial - transit	Medical	X UNPENDED X AMEND	<sub>ED</sub> 4b,23a,27,28a-	-i.per ME G883 9	/5/08 TT		
760, icate be physicite the burit	ş	22h Man decodest program to the	ves, outcome of pregnancy	2 Estado aragr	200011	23d. Date of deliver Month	ry Day Year
c 68	sician/I	past 12 months?	annual of time of death	etal death 3 Ectopic pregr ther (Specify)	lancy	World	Day Ica
Box 687 e death certifice the attending p ed for use as th	iysi	1 Yes 2 No 9 Unknown 9 U	nknown				
P.O. B	by Phy	Part II. Other significant conditions contributi	ng to death but not resulting in the	underlying cause given in Part I.		acco use contribute to	
ords, P.C.  v requires that s been signed b should be deta							obably 4 V Unknown
cords, aw requir	Completed				24a. Was ar autopsy	prior to	completion of cause of
Reco	E				perform 1 ✓ Yes 2		
tal Rection: The certificate	Be	25. Was case referred to medical examiner?		26 Place of Death (Chec	k only one)		
hysic all dire	P	1 Yes 2 No	Inpatient 2 ER/Outpatient			esidence 6 🗸 Oth	er: Scene
n of ding Pl After funera		Natural E D	Date of Injury 28b. Time of Month, Day, Year)	Injury 28c. Injury at Work?		ow injury occurred  was shot	
Siol Attendeath death ector;	cati	2 Accident Investigation un					Rural Route Number, City
Division of Vital Records, lal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sted in by the funeral director, page 2 should I	Certification:	Suicide Could not be	Place of Injury - At home, farm, stre $unk$	et, ractory, office building, etc.	or Town, Sta	te)unk	dia Note Namber, Ony
Lospits Hour Unera		29a. Certifier	e best of my knowledge, death occu	rred at the time date and place ar	nd due to the cause	(s) and manner as sta	ated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	one) 2 ✓ Medical Examiner: On the ba	asis of examination and/or investiga	ition, in my opinion, death occurred	at the time, date a	nd place, and due to	the cause(s)
To Viii	Me	29b. Signature and title of certifier	ner stated.	29c. License number	1	29d. Date signed (M	onth, Day, Year)
		aue I?		O.C.M.E.		August 11, 200	8
		30. Name and address of person who completed					
		Ana Rubio MD. Assistant Medic	- AS .	Street, Baltimore, MD 2120	01		
	ate	31. Date filed (Month, Day, Year) 2008	2 Registrar's Signature	ule			
Regist	uell'	/	market and the	di ann			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 **Physician** 1145 Lueck Paul /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS BRADDOCK CAMPUS **CUMBERLAND** ALLEGANY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Dec 26, 1936 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 € M 2 □ F Months Days Hours MD 220-74-2070 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Exemiter must be retified at anones. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MD Allegany Cumberland 1 Yes 2 □ No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 P.O. Box 1722 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ **X**o If Yes, Give Year or Dates: Specify. ģ Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul H. Lueck Blanche Heiland Lueck မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 nephew Michael Stump 212 New Hampshire Cumberland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State St. Mary's Cemetery 8/19/2008 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List drify only cause on each line. Immediate Cause (Final disease or condition resulting in death) 10 N PNEUMONIA ASPIRAT **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be execute burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physiclan as the burial-Physician/Medical attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≽</u> 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy 1 ☐Yes 2 No ours after death. eral Director: After this certific filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Pesidence} \) Residence \( 6 \) Other (Specify) Certification: To 1 Tes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. the 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

AUG 2 5 200

DR.Alida

31. Date filed (Month, Day, Year)

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

& foods

			For	State of Maryland					giene 2 N	08 272	25
_			State Registrar		Cer	tificate of	Death	2. Date of Dea		3. Time of De	
Ph	ysicia	ın	1. Decedent's Name (First, Middle, Last)	v 0 .1				Month	Day \	Year	
	Medic		Timothy Brian  4a. Facility Name (If not institution, give si	McGrath		4b. City. Town, o	or Location of Death	August	4c. County of		a · III ·
E	kamine	er				Leonardt			St. Ma	rv's	
Eur	neral		St. Mary's Hospita  5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da	h	Birthplace (State or F Country)	-oreign
	ector		323-54-8824	M 2□F 50	Yrs.	Months Days	Hours Min.	06/14/	1958	Illinois	
p	and any		Usual Residence of Decedent	100 City	, Town or Lo	cation				10d. Inside City	Limits
arylar	dat	-	10a. State 10b. County							1 □ Yes 2	
Ba-f	otifie	Director	Maryland St. Mary	s Lexi	ngton	10f. Zip Code			10g. Citizen of Wh	nat Country?	
vith th	pe n		10e. Street and Number			·					
eath v	nust	eral	21560 America Stre	et 2. Was Decedent Ever in U.:	S. 13. \	20653 Was Decedent of I	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No	United S	- American Indian,	
ter de	dical Examiner must be notified at	Funeral	11. Marital Status  1 □ Never Married 2 🕅 Married	Armed Forces? 1 IXI Yes 2 □ No				o Rican, etc.)		, White, etc.	
urs af	xam	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	White	
2 ho	cal	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deced	dent's Usual Occu kind of work done	pation during most of worked)	king	16b. Kind of Bus	iness/Industry	
thin 7	Med	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	ed)	Ü			
ed wi	t, the	Con		2	Chief		19 Mother's Nam	ne /First Middle	U.S. Nav , Maiden Surname	<del>-</del> /	_
be fill	even	Be	17. Father's Name (First, Middle, Last)							<b>y</b>	
shiptering Line 2000 should be filed within 72 hours after death with the Maryland ind Mental Hygiene.	natic	은	Charles McGrath  19a, Informant's Name/Relationship (Type	no Brintl	10h Mailir	na Address (Stree	Patricia tand Number or Ru			State. Zip Code)	
12 st hand	traun					_	a Street,				
permit. Pages 1 and 2 should be filled within 72 ho opertment of Health and Mental Hygiene.	ther		Debra K. McGrath/W 20a. Method of Disposition	20b. P		osition (Name of matory or other pla		Date		City or Town, State	
Pages 1 and the ment of He	0.0		1 ☐ Burial 2 🛣 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State I			1	2/2009	Charlatt	o Holl MD	
it. Partme	injur)		21. Signature of Funeral Service License		nsilei 2	2. Name and Addr				e Hall, MD L Home, P.A	
permit. Depart	any in		Kyle S. Simons	M01206			lywood Ro				
110			23a, Part1. Enter the disease, or compli	cations that caused the deat						Approximate Interval Between	
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	dical		disease or condition resulting in death)	Due to (or as a conseq	uence of):	1,631,	•			12945	
Exan	niner			COPD	EXAC	erbati	in.			1,75.7.3	
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):		canc	4 (		month	S
be executed	ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	me +asta		Cavis	) ( ) ( )				
6 exe	lan al urial-1	E	resulting in death) Last	Due to (or as a conseq	uence of):						
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ath cer	attend for us	Physician/M	in the past 12 months?	1□Live birth 2□Feta 4□Pregnant at time of o	aldeath 3	□Ectopic pregnan □ Other (specify)	су		Mor		ear
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that t	ed by detac		Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	underlying cause g	jiven in Part I.	23e. Did	tobacco use contr	ribute to the cause of de	ath?
ecords,	og pri	d by						1)🗷	Yes 2 □ No	3 ☐ Probably 4 ☐ Ur	nknown
	beer shou	Completed						24a. Wa		Were autopsy findings a	vailable
를 <sup>을</sup> 다	2 23	dmc			-			auto per 1☐ Yes	formed?	orior to completion of cau death? I □Yes 2 □ No	use of
	ifficat or, pa	Ö	25. Was case referred to medical				26. Place of De			2.00 22.00	
Or VIIA Physician:	is certificate ha director, page	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	]ER/Outpatie	ent 3 DOA	ther: 4 \sum Nursing I	Home 5□Res	sidence 6 Oth	er (Specify)	
9 H B	After this funeral di	H.E	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time	of 28c. In	jury at ork?	28d. Describe	how injury occurr	ed	
VISION Attending or death.	nr: Aff	atio	1 Natural 5 Pending 2 Accident investigation	(moral, Day 1 car)	,,		☐ Yes 2 ☐ No				
VIS r Atte	recto by th	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, s	treet, factory, offic	е	28f. Location City or To	(Street and Numb own, State)	er or Rural Route Numb	oer,
tal or	al <b>Di</b> led in	Certification:									
lospi t hou	uner ely fill		(Check only 2 Medical Exam	sician: To the best of my kniner. On the basis of examin	owledge, dea ation and/or i	th occurred at the investigation, in m	time, date and plac y opinion, death occ	e, and due to th curred at the time	e cause(s) and ma e, date and place,	and due to the cause(s)	)
DIVISION OF To the Hospital or Attending Phys within 24 hours after death.	the I	Medical	one) 29b. Signature and title of certifier	and manner stated.			nse number			d (Month, Day, Year)	
5. <u>¥</u>	<b>P</b> 00		23D. Signature and title of certifier						201.	2/2005	~/
				omeniated across of all-alls (the	m 22a\ /T	DOC DOC	161/17		001	a laco.	7
			30. Name and address of person who c				ad, Holly	Trood M	D 20626		
36	St	ate	Dhanajay Bhavsar, 31. Date filed (Month, Day, Year)	M.D. 24033 32. Registrar's Sign	ature	NOLCH KO	au, norry	wood, M	u		
	Renist		BUO 1 4 2000		- 12 0						

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 18-06181 State of Maryland / Department of Health and Mental Hygiene Patrick C Miller Certificate of Death Reg. No 1- For State 2. Date of Death Registrar Month Day August 12, 2008 Decedent's Name (First, Middle,Last) 2222 hrs Physician/ Medigal Examiner Miller Connor Patrick c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) St. Marv's Leonardtown Saint Marys Hospital Date of Birth(MM/DD/YYYY)
 G. Birthplace (State or Foreign Country) If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Min Hours **Funeral** Months Days 10/11/2005 Maryland Yrs Director  $_{1}X$  M 2 F 218-73-3888 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location Yes 2 X No 10b. County 10a, State 23a or 28a-f show notified at once. Avenue Mary's 10g. Citizen of What Country? Maryland St. 10f. Zip Code 10e. Street and Number United States 20609 23195 Colton Point Road 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral Armed Forces? must be 2 1 X Never Married filed within 72 hours after death 2 X No Yes Specify: White Yes 2 X No specify: Divorced If Yes, Give Yeer Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done þ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Never Worked other than than imore, MD 21215-0036 Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene. Never Worked 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Krystal A. Kaldenbach 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) marked Be James L. Mi<u>ll</u>er 19a, Informant's Name/Relationship (Type, Print) 2 20609 23195 Colton Point Road, Avenue, Maryland If item 27 is Krystal Kaldenbach/Mother 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition

1 Burial 2 ACremation 3 Removal from State crematory or other place) Baltimore, Brinsfield-Echols Cre 08/18/2008 Charlotte Hall, MD permit. Page Department o Important: injury or oth Donation 5 Other Specify 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21 Signature of Funeral Service Litensee
Edward N. Brinsfield, 22955 Hollywood Road, Leonardtown, 20650 Jr. M00052 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician Death failure. List only one cause on each line a Upper Respiratory Hemorrhage "Medical Immediate Cause (Final disease ıminer Due to (or as a consequence of): or condition resulting in death) b. Eroded Tracheal Ulcer Complicating Muscular Dystrophy Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical **AMENDED** UNPENDED attending physician for use as the burial 23d. Date of delivery The law requires that the death certificate be 23c. If yes, outcome of pregnancy Box 68760, Year Month IF FEMALE: 3 Ectopic pregnancy Fetal death 23b. Was decedent pregnant in the Live birth signed by the attending be detached for use as past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, P.O. ò 24b. Were autopsy findings available 24a. Was an Completed pnor to completion of cause of autopsy performed? death? 1 🗸 Yes 2 has ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Other<sub>4</sub> Be Residence 6 Nursing Home 5 DOA examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 1 Yes 28d. Describe how injury occurred After this 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Yes 2 No Certification: 1 V Natural Pending 28f. Location (Street and Number or Rural Route Number, City after death. Director: the Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) Could not be 3 Suicide (Specify) determined To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Homicide 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 1 Medical 29d. Date signed (Month, Day, Year) and manner stated 29c. License number 29b. Signature and title of certifier August 13, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD 32. Registrar's Signature 31. Aug iled Manth Day Year) State Registrar **ORIGINAL** 

DHMH 17 Rev 1/2001 OCME 2006 OCME

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 Calbert Howard Milstead /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles Piata Medica Center La Civista If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Months Days Hours 90 214-16-3979 Director July 5, 1918 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Injury or other traumatic event, the Pedical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Charles Indian Head 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or Items 23a or 20640 5200 Chicamuxen Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Higiene. Important: If Item 27 is marked other than "any Injury or other trainments." Elementary/Secondary (0-12) College (1-4or 5+) Carpenter U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Milstead Ethel Virginia Wheeler Edward 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Ella B. Milstead 5200 Chicamuxen Rd., Indian Head, Md. 20640 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Chicamuxen United Methodist Church Chicamuxen, Maryland 22. Name and Address of Facility Williams Funeral Home, P.A. 21. Signature of Funeral Service Licens M00668 4270 Hawthorne Rd., Indian Head, Md. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, . List only one cause on each line. 23a. Part 1. Enter the dis shock, or healt fail Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Dav Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate Yes within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🖭 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 A Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not he 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

P.O. Box 68760, Division of Vital Records,

Baltimore, Maryland 21215-0036

Track

The law requires that the death certificate be executed Hospital or Attending Physician:

Registrar

To the within 2 To the F

State

Medical

29b. Signature and title of certifi

and manner stated

29d. Date signed (Month, Day, Year)

D-0008370

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Venue P.O. Box 1317 La Plata, MD 20646 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** 5:45  $P^{M}$ AUGUST 2008 GLORIA L. MOYE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner PRINCE GEORGE'S 5826 GALLOWAY DRIVE OXON HILL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, **Funeral** Vear Days Hours Months 1 □ M 2 🗓 F Yrs Director VA <u>577-56-2156</u> MAY 24, 1941 Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ed other than "natural", or items 23a or 28a-f showevent, the Medical Exemples in ust be notified at 1 X Yes 2 No Director MD PRINCE GEORGE'S OXON HILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5826 GALLOWAY DRIVE 20745 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify Specify: \$ 3 X Widowed 4 □ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important; if item 27 is marked other than "ne any injury or other traumatic event, in Mental to once. Elementary/Secondary (0-12) College (1-4or 5+) YR HOME CARE AIDE CONTRACTOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALBERT ROY HUGHES RUTH LEWIS ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5826 GALLOWAY DRIVE OXON HILL, MD MICHELLE COLLIER / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08-12-2008 SUITLAND, MD 4 □ Donation 5 □ Other (Specify) CEDAR HILL CEMETERY 21. Signature 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 20746 4308 SUITLAND ROAD SUITLAND, MD DONALD R. GRAY complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Pa Enter the disease. ck, or heart failure. Imme ate Cause (Final disease or condition resulting in death) months **Physician** Metastatic Cancer of the Colon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🎇 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 □Yes 2 🕅 No 1 ☐ Yes 2 ☐ No Division of Vital Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 💢 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: of or Attending Fafter death. After 5 ☐ Pending investigation 1 X Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No filled in by the 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only and manner stated within 2. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) AUGUST 7, 2008 D18545 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Registrar AUG 1 1 2008

PHILLIP

31. Date filed (Month, Day, Year)

WISOTSKY

WALDORF, MD

20602

12070 OLD LINE CENTER #207

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1:00 pM 2008 05 Tony Morgan August /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hyattsville 8618 Riggs Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ♣M 2 ☐ F 577-17-7234 April 30, 1949 Delaware Director 59 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It a Medical Examination and Injury or other traumatic event, It a Medical Examination and Injury or other traumatic event, It a Medical Examination Director 1 ∏Yes 2 k No Hyattsville Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 20783 U.S.A. 8618 Riggs Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: Specify: ģ 3 Widowed 4 Divorced Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed 12 Construction Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Jerry Pedro Catherine Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Morgan - Daughter 8410 Adelphi Road, Adelphi, Maryland 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery 08/09/2008 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility **Hines-Rinaldi Funeral Home, Inc.** 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cardiac Arrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Coronary Artery Disease 15 years attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical 20 years Atherosclerosis IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Diabetes 1X Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? /es 2 🛣 No certificate 1 Yes 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1⊠Yes 2□No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🖳 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated.

Box 68760 P.0. Records, Division of Vital To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica yompletely filled in by the funeral director, p

Maryland 21215-0036

Baltimore.

State Registrar

(1

31. Date filed (Month, Day, Year) AUG 08

Rashid Baghai Naini, M.D.,

2008

29b. Signature and title of certifier

39. Registrar's Signature

NUNNE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

344 West University Blvd., Suite 324, Silver Spring, Maryland 20901

Mb

29c. License number

D39372

29d. Date signed (Month, Day, Year)

August 7, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUGUST **Physician** 4, 2008 NICHOLAS GARDELL 1330 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital MONTGOMERY Rockville 8. Date of Birth (Month, Day, Year) Apr. 16,1978 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days Hours Min. 1**y** M 2□ F 213-92-8831 30 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Exerciper must be recitived at 1 ☐ Yes 2 ☐ No Directo MD Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with iment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Modical Examination must be a 14530 Jones Lane 20878 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Bace - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify. þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) **9 Th** College (1-4or 5+) Unemployed None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leonard G. McRae Carolyn R. Talley ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carolyn R. Talley (Mother) 14530 Jones Lane, Gaithersburg, Mu 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☐ Burja) 2 Cremation 3 ☐ Removal from State Ardent Crematory 8/9/08 Hanover, MD 4 □ Dønetion 5 □ Other (Specify) Signature of Funeral Service L 22. Name and Address of Facility SNOWDEN FUNERAL HOME, F.A. 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Pulmonary Edema Sequentially list conditions, if any, leading to furnished cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of Examine physician and s the burlal-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical signed by the attending place as as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed r this certificate had rail director, page 1 ☐Yes 2 ☐ No 1 ☐Yes 2 ANO Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 29c. License number ၉ DO. H66189 8/4/08 d cause of death (Item 23a) (Type, Print) 30. Name and address of person who comple Meenakshi Andrew, 9901 Medical Center Dr, Rockville, MD 20850 M.D. 327 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

AUG 0 8 2008

Division or Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

State Registrar

Medical

29a, Certifier

29b. Signature and title of ce

31. Date filed (Month, Day, Year)

AUG 0 8 2008

Raman Tuli, M.D. 10810 Darnestown Road Gaithersburg, Maryland 20878 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D19609

29d. Date signed (Month, Day, Year)

August 7, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9:37 pm 04 2008 Nancy Marter August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 M 2 K F 70 Yrs. California **Director** 213-40-6019 June 16, 1938 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanciant must be notified at any injury or other traumatic event, the Medical Evanciant must be notified at once. 1 ☐Yes 2KNo Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 407 Quaint Acres Drive 20904 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ∐Yes 2 🕱 No Yes, Give 1 ☐ Never Married 2 🕱 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ⋛ Specify 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilfred Walter Eastman Mary Elizabeth Hyatt ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 Quaint Acres Drive, Silver Spring, Maryland 20904 Dr. Lyndon Marter - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 08/12/2008 Brentwood, Maryland 21. Signature of Funeral Savide Licer see 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. kg/l 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respirebry **Physician** disease or condition Cute 12 hours /Medical Due to (or as a consequence of Examiner Ulmonary years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed 10 years Lupus sician and burial-tran Systemic Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown signed I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe of Vital 1 □Yes 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑npatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. the 2 Accident after death 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 \( \text{Homicide} \) To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D12582 August 5, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Takoma Park M9 20912 7600 Carroll Avense Alfred MO MUNZEY

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 08

2008

32 Registrar's Signature

		For State Registrar		Stat	e of Ma	ryland		artment of I rtificate of		nd Ment		ene	2008	2726	6
		Necedent's Nam	ne (First, Middle, L	ast)							ate of Death			3. Time of Deat	
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/Medic Examin		4a. Facility Name (	<del>-</del>					4b. City, Town, o	or Location of D	Death		4c. C	ounty of Death		
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Funeral		5. Social Security N		Sex 1 ☐ M 2 🗵			ast birthday, Yrs.	If Under 1 Year Months Days		Min. (N	ate of Birth fonth, Day,	Year)	Cou	place (State or For ntry)	0
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ter death with the Marylan items 23a or 28a-f show iner must be notified at		4440 We	lls Park					2078					ed Stat		
er de: items	Funeral	11. Marital Status		Arme	Decedent E		5. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin an, Mexican, P	n? (Specify Y Puerto Rican	es or No- , etc.)	1.	<ol> <li>Race - Ameri Black, White,</li> </ol>		
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Page nent c int: If iry or			☐ Cremation 3 5 ☐ Other (Spec		from State			coln Ceme	i i	-20-20	08	Blad	densburg	, MD	
permit. Pages 1 and 2 should be filed within 72 hours. Department of Health and Mental Hygiene. I mortant: If flem 27 is marked other than "natural", any injury or other traumatic event, the Medical Exagnore.		21. Signature of F	uneral Service Lic	ensee AL	W01	_		2. Name and Addre	ass of Facility					ily FH, I	nc
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Physical direction	P.	1 ☐ Yes 2 2 27. Manner of Dea	•	Hospital:			ER/Outpatie	III 3 LI DOA			5 Reside Describe ho			ity) HOSPICE	
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Atten r deat sctor:	fica	3 ☐ Suicide	6 Could not	ha	Place of Inju	ry - At hoi	me, farm, si	reet, factory, office		28f. L	ocation (Sti	eet and	Number or Rui	ral Route Number,	
al or s after al Dire	Certification:	4  Homicide	abtolilline.		building, etc	. (Specity	′)				ity or Town	, State)			
To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending tompletely filled in by the funeral director, page 2 should be detached for use as	Medical (	29a, Certifier (Check only one)		aminer: On		examinat		th occurred at the to nvestigation, in my							
To the within To the compl	Me	29b. Signature and	d title of certifier		7			29c. Licen	se number		25	d. Date	signed (Month	, Day, Year)	
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(A).0		30. Name and add						Print)				J		204	
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08-06294 Alexis Markov

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 27267 Certificate of Death Reg. No. 1- For State 2. Date of Death Registrar 1. Decedent's Name (First, Middle,Last) Month Day August 17, 2008 0547 hrs Physician/ Medical Examiner Michael Markov Alexis 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24Hrs. 8, Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Country) 5. Social Security Number **Funeral** Months Days Hours April 13,1983 Virginia 25 Director 230-29-5087 Yrs 1X M 2 F Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 X No Gaithersburg 23a or 28a-f show notified at once. Maryland Montgomery hours after death with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20882 23905 Hawkins Creamery Court Ճ 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 X Never Married 2 White Yes Yes 2 X No specify: Specify: If Yes Give Year Divorced Widowed 16b. Kind of Business/Industry "natural", <u>≥</u> 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) pleted in: Pages 1 and 2 should be filed within 72 hou ritheatt of Health and Mental Hygiene.

-tant: If item 27 is marked other or or other traver. Attending University College (1-4 or 5+) Elementary/Secondary (0-12) Student 2 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ellen Plant Barbara Markov Be Serge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 23905 Hawkins Creamery Ct., Gaithersburg, MD 20882 Serge Markov / Father 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Baltimore, Burial 2 X Cremation 3 Removal from State Edgewater, MD 8/19/2008 Kalas Crematory permit. Pages
Department of
Important: 1 Donation 5 Other Specify <sup>22</sup> Name and Address of Facility George P. Kalas Funeral Home, 6160 Oxon Hill Rd., Oxon Hill 21. Signature of Funeral Service Licensee 20745 Kelis 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician tailure. List only one cause on each line. Death 'Medical Methadone intoxication Immediate Cause (Final disease aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit 4b,23a,27,28a-t, per ME g883 9/30/00 11 Physician/Medical X UNPENDED AMENDED attending physician for use as the burial To the Hospital or Attending Physician: The law requires that the death certificate be e within 24 hours after death. 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year Day Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death I ive birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 ✔ Unknown 2 24b. Were autopsy findings available 24a. Was an Completed prior to completion of cause of 2 should autopsy death? performed' 2 No 1 🗸 Yes Yes 2 certificate bector, page 26.Place of Death (Check only one) After this certification funeral director, I 25. Was case referred to medical Be Residence 6 Nursing Home 5 examiner? DOA Hospital: 2 V ER/Outpatient 3 Inpatient 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: Yes 2X No Natural Fnd 8/17/08|Fnd 5:00 Pending 28f. Location (Street and Number or Rural Route Number, City or Town, State) 13412 Daventry Way Apt L Germantown, MD Funeral Director: stely filled in by the Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be 3 Suicide found at residence determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 18, 2008 O.C.M.E. 27 D 30. Name and address of person who can bette cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Russell Alexander MD. 31. Date filed (Month, Day, Year) Registrar's Signature **OCME** State

ORIGINAL

Registrar

			State of Maryland / De	•	and Mer	ntal Hyg	iene	
			Registrar	ertificate of Death	-	Date of Deat	eg. No. 200	8,27268
f	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Mary N. Moss			Month 8-17-20		9:50 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of	f Death		4c. County of D	
			Vindobona Nursing Home  5. Social Security Number   6. Sex   7. Age (In yrs. last birthd	Frederick  J If Under 1 Year   If Under 2	24 Hrs. T 8	Date of Birth	Freder	ILCK Birthplace (State or Foreign
	Funeral Director		214-10-5286 1 M 2 M F 91 Yrs	Months Days Hours	Min.	Date of Birth (Month, Day, 11-3-1	916	Country) MD
	pu ,		Usual Residence of Decedent					10d. Inside City Limits
	haryla   shov	ō	10a. State   10b. County   10c. City, Town of the county   1					1 ☐ Yes 2X No
	the N	Director	MD Frederick Freder  10e. Street and Number	10f. Zip Code		11	0g. Citizen of What	: Country?
	th with	alD	8903 A Yellow Springs Road	21702			USA	
	tems terminated	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,	gin? (Specify , Puerto Ric	y Yes or No- an, etc.)		American Indian, /hite, etc.
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 📉 No If Yes, Give Year or Dates:	1 ☐Yes 2X No Specify:			Specify:	White
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anc	d be fi	Be C	Guy E. Nusz	Ne1		nst, wildae, n	naideir Gurname)	
Maryland 21215-0036	should and Me mark umati	To		ailing Address (Street and Numbe		loute Number	; City or Town, Stat	te, Zip Code)
	12 th 27 14 tra		Deborah Kefauver , Niece 461	l Mockingbird Lr	n Fred	erick,	MD 21703	3
Baltimore,	jes 1 a t of He if item or oth		20a. Method of Disposition 1 № Burial 2 □ Cremation 3 □ Removal from State	sposition (Name of crematory or other place)	Date	•	20c. Location - City	or Town, State
ᆵ	t. Pages rtment of I rtant: If its		4 □ Donation 5 □ Other (Specify) Mount O	livet Cem. 8	3-20-2	800	Frederic	k, MD
Ba	permit. Pages 1 and Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licenses  MO1176	22. Name and Address of Facility 106 East Church		-		
	_		28a Part . Enter the disease, or complications that caused the death. Do not					Approximate Interval Between
_	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Cardiomyopat	hv				Onset and Death
أر	/Medical Examiner		resulting in death)  Due to (or as a consequence of):					•
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8	death atten	cian	1 Live birth 2 Fetal death to the past 12 months?  1 Vac 2 No. 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month Month	Day Year
Division of Vital Records, P.O. Box	it the by the tached	Physician/Me	9 Unknown					
s,	es the	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.				te to the cause of death?
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ta	an: T tificat tor, pa	Be Co	25. Was case referred to medical	26. Place	of Death (C	1 □Yes 2 Check only on	At .	Yes 2 No
>	nysici nis ce I direc		examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	Other:			ence 6 Other (	Specify)
o u	ding Physician: The h. h. After this certificate h. funeral director, page	on:	27. Manner of Death 1 Anatural 5 □ Pending (Month, Day, Year) 28b. Time (Month, Day, Year)	ry Work?		d. Describe ho	ow injury occurred	
Sic	death ctor: y the f	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	M 1 Yes 2 1		. Location (St	treet and Number o	or Rural Route Number,
<u>S</u> .	al or A s after I Dire	Certification: To	4 ☐ Homicide determined building, etc. (Specify)			City or Town	n, State)	
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier (Check only (Ch					
	thin 2, the P	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License number			9d. Date signed (M	
	5 × 5 0	_	250. Signature and the of Certifier	D60417		-	8-20	
			30. Name and address of person who completed cause of death (Item 23a) (Ty					- 2
	W		Dr. Hemen Shah M.D. 65-C THomas Joh	nson Dr. Freder	ick, N	1D 2170	)2	
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature	- M >-				
	ricgisti	CIT	AUG 2 5 2008	34.55				

DHMH 17 Rev 1/2001

Fausto Bonergent Orellano

2008 27269

		1- For State Registrar				Certif	ficate of	Death					Reg. No.		- 10	F (D	
Physici	an/	1. Decedent's Nam			. 0	110 1	1.50				1	Month	Day	Year		Time of Dea 1445 hrs	
l Exam	iner	Faus 4a. Facility Name (				11ano-A		o. City, Tov	wn orlo	ocation of		August 2		ounty of I	Death		
		Suburban +		on, give stree	t and numb	erj	"	Bethes					Mor	ntgome	ery		Ì
Funeral		5. Social Security N		6. Sex	7.	Age (In yrs. last	birthday)	If Under	1 Year	If Under	24Hrs.	8. Date of E	Birth (MM/DD)	(YYYY	9. Birthpla	ace (State o	T Odor
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any		10a. State	10b. County	1			own or Locatio									d. Inside Cit	
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Page ment of		4 Donation	5 Other	Specify:		Fan	nily Ce	meter	су				- 1				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants I filem 27 is marked other than "natural", or items 23a or 28a-f show any ining very other transmit event, the Nedical Examiner must be notified at once.	;	21. Signature of F	uneral Servi	ce Licensee	Ban	on CC3	22. N	ame and A	Bac	on Fu	iner	al Hor	ne, In ashing	c.	DC	20010	)
_	_	23a. Part I. Enter	the disease	or complication	ons that cau	sed the death. I	Do not enter to	ne mode of	f dying,	such as ca	ardiac or	respiratory	arrest, shock	k, or hea	rt T	Approximat	e intervai
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ion tendii eath tor: /		1 Natural 2 Accident		ending rvestigation						Yes 2 ✔						I Don't No	-bas City
Division of Vital Records, tal or Attending Physician: The law requints after death.  By Director: After this certificate has been sized.		3 Suicide	6 C	ould not be		of Injury - At ho		eet, factory	, office t	ouilding, e		or Toy	on (Street ar				mber, City
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Functor: After this certificate has been signed by the attending physician and To the Functor and After this certificate has been signed by the attending physician and			Certifying  Medical F	g Physician: Examiner:On	To the best the basis o	of my knowledg	ge, death occu nd/or investiga	urred at the ation, in my	e time, d y opinior	ate and pi n, death o	iace, and ccurred a	at the time,	cause(s) and date and pla	ce, and o	due to the	cause(s)	
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16		30. Nam⊋and ad Melissa B				e or death (item dical Examir		Penn St	reet, E	Baltimo	re, MD	21201					
•	State											· · ·					
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ORIGINAL

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Mary Evelyn Perkins 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Hospice at the Lake (COMICO If Under 1 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Days Min. Hours 1 □ M 2 🛛 F Months 212-16-2763 88 Dec. 10, 1919 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Marvland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1514 Riverside Drive 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 21 No If Yes, Give Year or Dates: Specify 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Union Memorial Hospit. Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wilbur S. Cook Eva Hasson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Riley/son-in-law 1707 Eastgate Drive - Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Aug. 11, 2008 Salisbury, Maryland 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD Signatur of Funeral Service JOLLEY MEMORIAL CHAPEL, P.A. 23a. Part 1. Enter the disease, or complications of at caused the de th. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final yrs disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. if yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 L Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 No 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a. State

Director

Funeral

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Completed

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Funeral

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, If a Medical Exhaulter must be a collined and

Baltimore, Maryland 21215-0036

Examiner Physician/Medical ð

physician and the burial-trans attending p as ed by the a s been signed be should be deta s certificate has b irector, page 2 sf

The law requires that the death certificate be executed

Box 68760.

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Division of Vital Records,

To the Hospital or Attending Physician:

Completed Be After this funeral dire Certification: To within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an autopsy performed? 1 ☐ Yes 2 K No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospica 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

361

State Registrar

Medical

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. BELLOSOM. D. 5302 GREGORIO

CHINABERRY DR. SALISBURY MD 21801

D 29505

29c. License number

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?

2 🔀 No

1 ☐ Yes

nysicia		For State Registrar  1. Decedent's Name (First, Middle,	(act)	Ce	ertificate of D	eath	Reg	j. No.	3. Time of Death
Medic	an al	Rebecca Jos	ephine Pi	ice		·	Month August 8	Day Year <b>2008</b>	3. Time of Death
xamin		4a. Facility Name (If not institution, g			4b. City, Town, or L	ocation of Death		4c. County of Dea	
		Charles County			LaPlata	W.Ud0411		Charles	
neral ector		219-14-3202	. Sex 1□M 2 X F 7. Age 86	(In yrs. last birthda) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1)	00	thplace (State or Forei ountry) WA
-		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limit
e pe	ō	MD Char	100	W-11					1 Yes 2 N
Though I	Director	10e. Street and Number	162	Waldorf	10f. Zip Code		100	g. Citizen of What Co	ountry?
N De		1022 Dartmouth	Road		2060	)2		USA	
E E	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13	. Was Decedent of His If Yes, specify Cuban	panic Origin? (Sp	ecity Yes or No-	14. Race - Ame Black, Whi	
	by	1 ☐ Never Married 2 ☐ Married			1 ☐ Yes 2 No	Specify:	ritoari, otc.,	Specify:	ite
1	ted	15. Decedent's (Specify only highest)	Education	16a. Dec	edent's Usual Occupat	ion	16	5b. Kind of Business	
	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	life.	e kind of work done du DO NOT use retired)	ring most of work	ing	Dept of P	arole and
	Con	12	2	. 1	Secretary			Probation	
	Be	17. Father's Name (First, Middle, La	st)	"Selection of	_ 1	18. Mother's Name	e (First, Middle, Ma	aiden Sumame)	
	은 .	Elmer Brown				Bertha W	lienicki		
		19a. Informant's Name/Relationship	(Type, Print)		ling Address (Street an			•	Zip Code)
	-	Joe Ann Price/da	aughter	1022	Dartmouth	Road, W	aldorf,	MD 20602 Dc. Location - City or	- T State
5		1) Surial 2 Cremation 3			position (Name of ematory or other place)				
	-	4 □ Donation 5 □ Other (Spe		1.	d Cemetery			rincess A	nne, MD
ouce	1	21. Signature of Funeral Service Lice		H	22. Name and Address Linman Fune	ral Home			
_	-	ATTUS A VICE		0295 1	<u> 1673 Somer</u>	set Ave.	. Princes	ss Anne, 1	MD 21853 Approximate
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cal ner		resulting in death)	Due to (or as a	consequence of):	10 17000		•		
	6	Sequentially list conditions, it any, leading to immediate	b. Due to for as a	CONSEQUENCE OF.					
	Examiner	cause. Enter Underlying Cause (Disease or injury							
	Exa	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event; the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

Physician

Examin

Funeral Director

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

/Medic	al	Sherlin Ruth	Porter			A1		4, 2008	
xamin	er	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or Locati	ion of Death	4	c. County of Dea	th
	T	Prince Georges	Hognital		Charrant			Daines	C
		5. Social Security Number 6. So		st birthday)	Chever 1		Date of Birth	Prince 9. Bir	Georges thplace (State or Foreign
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ector		435-76-1546	6	U			oct.27,	1947 I	ouisiana
>	1	Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Loc	ation				10d. Inside City Limits
at bo	_	Toa. State Tob. County	Too. Oity,	TOWIT OF LOC	ation				1 X Yes 2 No
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28 10	Director	10e. Street and Number	-		10f. Zip Code		10g. C	itizen of What C	ountry?
a o		7200 01- 7	- 12						
s 23	era.	7208 Greely R	Oad 12. Was Decedent Ever in U.S	10.14	20785 as Decedent of Hispanio	Origin? (Specif	U1	ited S	tates
er n	Funeral	11. Marital Status	Armed Forces?	. 13. Vi	Yes, specify Cuban, Me	xican, Puerto Ric		Black, Whi	
a in		1 ☐ Never Married 2☐ Married	1 ☐ Yes 2 XNo If Yes, Give	1	☐Yes 2☑No Spe	cifv:		Specify: D 1	_
Exa Exa	þ	3 ☐ Vidowed 4 ☐ Divorced	Year or Dates:					B.J	ack
cal	Completed	15. Decedent's Ed	lucation	16a. Decede	ent's Usual Occupation	mast of working	16b.	Kind of Business	/Industry
Aed Aed	be	(Specify only highest gra	College (1-4or 5+)	life. D	ind of work done during on NOT use retired)	most or working			
tha he N	E	Elementary/Secondary (0-12)	<b>∆</b>	Cler	k Typist		E.	ed. Gov	vernment
nt, t		17. Father's Name (First, Middle, Last)		0101		lother's Name (F	irst, Middle, Maide		етишенс —
eve eve	Be							ŕ	
arke atic	ဂ္	O.C. Boyd Jr			Es	<u>ssie L.</u>	<u>. Austir</u>	1	
EE		19a. Informant's Name/Relationship (	Type. Print)		Address (Street and Nu		Route Number, City	or Town, State,	Zip Code)
27 ii		Stefanie Porte	r/daughtor	7208	Greely Ro	oad			
the		20a. Method of Disposition	20b. Pla	Land ace of Dispos	over Md . ition (Name of atory or other place)	$\frac{20785}{5}$	9 20c.	Location - City or	r Town, State
or it		1 Burial 2 □ Cremation 3 □	nemoval nom state			1		•	
Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 ☐ Other (Specification)	// Ft.	Linc	oln Cem.	: 8/22/	'08   Br	centwoo	d, MD.
ie in		21. Signature of Funeral Service Licer	isee / 1	22.	Name and Address of F	acility Hoc	daes & F	Edwards	F.H.
a a		b loanna.	Hada	3	910 Silver	r Hill	ra ba	iitland	.Md.20746
		23a Part Enter the disease or com	plications that caused the death	Do not ente	r the mode of dving suc	h as cardiac or r	espiratory arrest	riciano	Approximate
		23a. Part. Enter the disease, or com shock, or heart failure. List only	one cause on 🎜 h line.	1 . 1		1 11			Interval Between Onset and Death
sician		Immediate Cause (Final disease or condition	· atal	ara	ac Urr	NYXRA	ia		
edical		resulting in death)	to (or as a conseque			1			
miner						8			
	<u></u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseque	ence of):					
# tis	Ē	cause. Enter Underlying	Dao to (or ao a conceda.						
ran	Examiner	that initiated events	C						
by the attending physician and ached for use as the burial-transit		resulting in death) Last	Due to (or as a conseque	ence of):					
sicia bo	g		- d						
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ding se a	hysician/Medical	IF FEMALE:	23c. If yes, outcome pf pregnan	CV				02d Date of de	olivon
ten or us	an	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal	death 3 🗆	Ectopic pregnancy			23d. Date of de Month	Day Year
ed fo	sici	1 ☐ Yes 2 ☑ No	4□Pregnant at time of de 9□Unknown	ath 5□	Other (specify)				
by #	hÿ	9 ☐ Unknown							
	₾	Part II. Other significant conditions	ontributing to death but not resul	ting in the un	derlying cause given in F	Part I.	23e. Did tobacco	use contribute	to the cause of death?
sign d be	d by						1 ☐ Yes	2 No 3 F	Probably 4 Unknown
lnor	Completed								
as b 2 st	ple						24a. Was an autopsy		autopsy findings available completion of cause of
age	E						performed?	death?	-A
ifica or, p		25. Was case referred to medical			00.5	Diago of Dooth /		ТШТЕ	7
ect	Be	examiner?	Hospital:		Other	Place of Death (			
this dir	은	1 Tes 2√2 No	1 ☐ Inpatient 2 ☐ E	R/Outpatient	3 DOA 4		5 Residence		ecify)
nera		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28	d. Describe how in	jury occurred	
e fu	atic	2 Accident investigation			M 1 ☐ Yes	2 🗆 No			
y th	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At not	ne, farm, stre	et, factory, office	28	f. Location (Street	and Number or I	Rural Route Number,
Dire in b	Ĭ	4 Homicide determined	building, etc. (Specify)				City or Town, St	ate)	
led	ŏ						4.4	(-) ·	
To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be de	edical		rysician: To the best of my know miner: On the basis of examinati						
he F plete	edi	one)	and manner stated.			,			(-/
To the	Me	29b. Signature and title of certifier	/		29c. License num	ber	29d. [	Date signed (Mo	nth, Day, Year)
,- 0			Marth in	A	DERG	57		3-15-0	18
			vario,	- 0	D589	21	1	1120	D
		30. Name and address of person who	completed cause of death (Item		Print)	1	117 1	0701	
		Dr. Gary Little	3001 HOSDITA	U DI	ive Cher	evly -	UD 2	1485	
Sta	ate	31. Date filed (Mortth, Day, Year)	32. Registrar's Signat	ure			ŧ		
Regist		AUG 2 5 2008	A se	1	0 US-				
		1100 D 0 2000	Garage of the same	ASSESSED ASSES	A				

within 24 hours at To the Funeral D

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric Berg, MD 110 Hospital Road, Prince Frederick, MD 20678 31. Date filed (Month, Day, Year)

32. Registra Signature 2008

29c. License number

D0047153

29d. Date signed (Month, Day, Year)

08/11/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Michelle /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince HOSPITA Doctors anham If Under 24 Hrs. 9. Birthplace (State of Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F Months Min 24 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyghen. Important: If time 27 is anaked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mudical Examiner must be notified at Yes 2 No Director 19e0 19e5 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 ∐Yes 251No If Yes, Give Year or Dates: 1 □Yes 2 VNo Specify Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of isposition 1 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner m96 5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and burial-tran Due to (or as a consequence of) attending physician Physician/Medical the use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρ Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 4 ☐ Pregnant at time of death signed by the a d be detached for 1 ☐ Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, page 1 □ Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 □ No 1 ☐ Yes investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records, or Attending

ハ*uつ*rコ , ロのりりの Baltimore, Maryland 21215-0036

To the Hospital 8 BY

State Registrar (Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year :00 AM ter 2008 19051 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 8. Date of Birth (Mgnth, Day, Year) 11/24/1943 Baltim ore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Sex 14 M 2 □ F 9. Birthplace (State or Foreign Country) Massachusetts Age (In yrs. last birthday) Months Days Min. Hours 022-34-5433 64 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits XXYes 2 □ No DC None Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3118 New Mexico Avenue NW 20016 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 23€ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+Foreign Policiy Analyst Foreign Policy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sumner Rodman Helen Morris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3118 New Mexico Ave. NW Washington, DC 20016 F. Veronique Rodman / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 X Removal from State Sharon Memorial Park 08/11/2008 Sharon, Massachusetts 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave. NW Washington, DC 20016 a led the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e.g. h line. 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis disease or condition resulting in death) Due to (or as a consequence of): Lymphoblesta Lerkenia Sequentially list conditions Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4☐Pregnant at time of death 1 Yes 2 No. 9 Unknown 9 Unknown

**Physician** /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed

After this

4 hours after death Funeral Director:

24

To the within 2

filled in by

10

Division or Vital Records, P.O. Box 68760,

**Physician** 

Examiner

**Funeral** 

Director

should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Item 27 is marked other than "natural"; or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at

tal Hygiene.

Mental h and Mental

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is rr any Injury or other traum once.

/Medical

Director

Funeral

Completed by

Be

2

Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-trar and ate has been signed by the attending physician page 2 should be detached for use as the burial

Physician/Medical

Completed by

Be

Certification: To

Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital:

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

autopsy performed?
Yes 2 No 1 Yes 26. Place of Death (Check only one) Other: 4 \sum Nursing Home

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 Natural

5 Pending investigation 6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Tes 2 No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

5 ☐ Residence 6 ☐ Other (Specify)

(Check only one)

2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

0 8 32. Registrar's Signature

6008

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Vasquez Ramirez Maria Aug.6,2008 2150 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) unty of Death Baltimore Towson Gilchrist Center If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 15, 1980 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday 1 ☐ M 2 🔀 F Guatemala 27 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Prince George' 1 ☐ Yes 2 No Hyattsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 20783 8130 15th Avenue Guatemala 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Guatemalan 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Children Child Care 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Micaela Ramirez Aguilar Juan Vasquez Lopez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8130 15th Avenue Hyattsville, Md 20783 Herculano Gomez Perez/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 Removal from State Municipal Cemetery San Martin, Guatemala 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lig PANTE PO AD PROTRALDI FUNERAL SERVICE, P.A. Mil peal Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YEAR disease or condition resulting in death) ue to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 □Yes 2 Who 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes PYLURI 24a. Was an 24b. Were autopsy findings available

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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MD

**Funeral** 

Director

1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Medic ONDE.

or Attending Physician: The law requires that the death certificate be executed and

Examine

Physician/Medical

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Be Completed

Certification: To

Medical

burial-tran attending physician the as use for the ģ signed I director, page 2 should has certificate this funeral After 24 hours after deatl Funeral Director: filled in by the

Division of Vital Records, P.O. Box 68760,

Hospital

9 Unknown	9 🗆 Unknown
	s contributing to death but not resulting in the underlying cause given in Par

		autopsy prior to completion of cause of death?  1 □ Yes 2 □ No 1 □ Yes 2 □ No
25. Was case referred to medical examiner?		26. Place of Death (Check only one)
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Of	her: 4 ☐ Nursing Home 5 ☐ Residence 6 ★Other (Specify) HOSPICE
27. Manner of Death  ↑★Natural 5 ☐ Pending 2 ☐ Accident investigatio	n M 1E	
3 ☐ Suicide 6 ☐ Could not be determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
		time, date and place, and due to the cause(s) and manner as stated. opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier.

29c. License number D64395

29d. Date signed (Month, Day, Year) ANGUST 7,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10565 NEMARLES ST, SUITE 209 BALTIMURE, MA 21204 DANIEUE DOBERMAN MO

State Registrar

completely To the within 2

> 31. Date filed (Month, Day, Year) AUG 0 8

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 🛛 🗎 🥈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AMonth AVGUS **Physician** 7008 1120 AM Armeda Roberts /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 200-14-7054 90 1918 April 4, Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MDWashington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21742 719 Antietam Drive U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 K If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White φ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Unknown permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 is marked other than any injury or other traumatic event, Ite Ma College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Charles Morris Virginia Hickey ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 719 Antietam Drive, Hagerstown, MD Ross Roberts, Jr./Husband 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 8/21/2008 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel SMar 1601 Pennsylvania Ave., Hagerstown, MD ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on/each line. 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final en **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Mepinous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit CO and or as a consequence of): Box 68760, physician Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 3 Probably 4 Unknown icate has been si, page 2 should b 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 € No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Lirector A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name indiaddress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

AUG 25

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

of Vital Records.

32. Registrar's S

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		For State	State of Maryl				Mental Hyg	iene	0.7070
		■ Registrar	43		ertificate of	Death		eg. No.	8 2 1 2 1 9
Physici	an	Decedent's Name (First, Middle, Las REECE	0 C.		STURGII	T	2. Date of Dear Month AUGUST		ar 3. Time of Death 11:58 A M
/Medic		4a. Facility Name (If not institution, give				or Location of Deat		4c. County of	
Examir	ier	FOREST HILL HEALT		ENTER		REST HILI		H.A	ARFORD
Funeral		Social Security Number     6. Security Number		yrs. last birthd	ay) If Under 1 Year Months Days		8. Date of Birth	, Year) 9.	Birthplace (State or Foreign Country)
Director		238-16-0034	<b>X</b> <sup>M 2□ F</sup> 9	2 Yrs	s. Moritaio Bayo		11/1/1		W. Carolina
and w		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or	Location		<u> </u>		10d. Inside City Limits
ite; Maryland ZIZID-UUJO s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	o	MD. Hari	ford			Forest	Hill		1 □Yes 2 No
the 28a-	Director	10e. Street and Number	.01 4		10f. Zip Code	101000		l 0g. Citizen of Wha	at Country?
h with	<u>=</u>	116 W. Jarret	tsville R	oad		21050		United	d States
deatl	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?		13. Was Decedent of H If Yes, specify Cub		Specify Yes or No-	14. Race -	American Indian, White, etc.
or Ite		1 Never Married 2 Married	Yes 2 □ No		1 ☐ Yes 2 <b>X</b> No	Specify:	,	Specify:	,
D-UU30 72 hours af natural", or	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: WW						White
"nat	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	16a. De	ecedent's Usual Occu <sub>l</sub> ive kind of work done fe. DO NOT use retire	pation during most of world)	orking	16b. Kind of Busin	erdeen
G CICI filed within Hygiene. other than '	E C	Elementary/Secondary (0-12)	College (1-4or 5+)		llistics				g Ground
Hyg Hyg other	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,	,	
riar y larro	To B	Roy 1	Teal	Stur		Ver			Atwood
Z short and helps man	-	19a. Informant's Name/Relationship (7	Type. Print) (Wife	/					ate, Zip Code) 21050
and		Katharine E. S			6 W. Jar				est Hill,MD
OTG ges 1 Fifer or oth		20a. Method of Disposition 1	Removal from State		isposition (Name of crematory or other pla		Date	20c. Location - Cit	
Salitimor  permit. Pages Department of mportant: If It iny Injury or o		4 ☐ Donation 5 ☐ Other (Specify	) Bel	Air I					, Maryland
Dallimore permit. Pages 1 Department of F Important: If Ite any Injury or ot		21. Signature of Funeral Service Light	200		22. Name and Addre	- 4			on Funeral
_ 10_0		23a. Part1. Enter the disease, or com	plications that caused the	death Do not	Home, P				Maryland Approximate
YELL	5 77	shock, or heart failure. List only	one cause on each line.	douin. Do not	=	ing, carried caracter	ar or respiratory an		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Due to (or as a co	nsequence of):	noses				
Examiner				11004401100 017.					
27	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence of):					
nd ransi	Examine	that initiated events	C						
cate be executed obysician and the burial-transit	Ä	resulting in death) Last	Due to (or as a co	nsequence of):	:				
X/ bU cate be e chysician the buris	dical		d						
as 🛊 🗗	Physician/Me	IF FEMALE:	23c. If yes, outcome pf pr	regnancy				and Date	of delivery
BOX eath cer attendir for use	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		23d. Date of Month	
the d	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown						
w requires that the deben signed by the should be detached		Part II. Other significant conditions of	ontributing to death but no	ot resulting in th	ne underlying cause gi	ven in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
cords v requires been sig	ed by	Coronaug ar	ley duce	<u> </u>			1 □ Y	'es 2 No 3	☐ Probably 4 ☐ Unknown
eco law re as bee 2 sho	Completed	0	,				24a. Was a	an 24b. We	ere autopsy findings available
<b>~</b> • ← •	E O						autop perfor	rmed?   dea	or to completion of cause of ath?
VITAL PISICIAN: The certificate rector, pag	a	25. Was case referred to medical examiner?				26. Place of De	eath (Check only of		
di is	To B	1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpa	atient 3 DOA Ot	her: 4 Nursing	Home 5 ☐ Resid	lence 6 DOther	(Specify)
<u> </u>		27. Manner of Death  Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Tim lnju	iry Wo		28d. Describe h	now injury occurred	ı
Attending r death. ector: After by the funer	atic	2 Accident investigation 3 Suicide 6 Could not be				]Yes 2□No			
UNISION  I or Attending after death. Director: After din by the fune	Certification:	4 Homicide determined	28e. Place of injury - building, etc. (S	At home, farm pecify)	, street, factory, office		28f. Location (S City or Tow	Street and Number vn, State)	or Rural Route Number,
pital purs a eral c		29a. Certifier 1 Certifying Ph	ysician: To the best of m	v knowledge o	leath occurred at the	time date and pla	re and due to the	rauca(c) and man	nar as stated
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: After completely filled in by the fur	edical		niner: On the basis of exa and manner stated.	amination and/					
omple	Mec	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (	Month, Day, Year)
F 5 F 0		David 50	D		0	32299		AND US5	·15,2007
,		30. Name and address of person who	completed cause of death	(Item 23a) (Ty		,		•	, ,
17		DAVID DUNN - 61	5 W. MACPHAI	IL ROAD	- BEL A	IR, MD.	21014		

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2008 7:03 August 8 AM Sens, Jr. John Roy /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Chesapeake Beach Calvert 6217 5th Street | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 04-02-1920 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex **Funeral** Wash., D.C. 1**∑**M 2□F 88 579-07-8264 Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d, Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 1 ☐ Yes 2 No Director Chesapeake Beach MD Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20732 6217 5th Street Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1945–46 1 ☐ Yes 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced white Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If Item 27 Is marked other tha any Injury or other traumatic event, the Item sheet metal worker construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Alberta Jenkins Sens. Sr. Roy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6217 5th St., Chesapeake Beach, MD 20732 Elizabeth T. Sens, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 8-9-2008 Alexandria, VA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Whiknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \text{Yes} \) 2 \( \text{LNe} \) 24a. Was an N page this certificate 2 -NO or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ⊟Natural 1 ☐ Yes 2 ☐ No ours after death.
neral Director: A
filled in by the fu 2 ☐ Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

within 24 hours a

To the Funeral C

completely filled i

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mathur, M.D., 110 Hospital Rd., Ste. 305, Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) AUG 11 2008 32. Registrar's Signature

State Registrar

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? () () () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0.8 **Physician** 09 Margaret Clarise Sampson 08 12:40 PM /Medical 4b. City, Town, or Location of Death Elkton 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Sunbridge Nursing Home Cecil if Under 1 Year | if Under 24 Hrs. Date of Birth (Month, Day, Year) 06-21-21 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🔀 F Days Hours Min Phila, Pa. 187-28-4837 Director 87 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Delaware New Caslle Director Newark 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 19711 U.S.A. 60 Darien Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify Specify: Black þ Maryland 21215-003 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Rusiness/Industry (Give kind of work done during most of working life. DO NOT use retired) Phila. Board than Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than of Education Dietician Aide 12 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H Iem 27 Is marked otl Be Franklin A. Friend Bertha S. Geary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trau Juanita S.Pritchett, Daughter 60 Darien Road Newark, Del. 19711 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 08-16-08 Burial 2 Cremation 3 Removal from State Willow Grove, Pa . Fairview Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility My Route 298 Worton, Maryland 21678 23a. Part. Enter the disease, or complications that caused the death. Do not enter the more of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sea 01 /Medical to (or as a const quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, s been signed by the attending physician should be detached for use as the huria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No.
9 Unknown Year Month 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Innatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Z Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 Homicide determined To the Hospital o within 24 hours aff To the Funeral D 29a. Certifier 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Da

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26. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month **Physician** EARL LEROY SHAFFER 4, 02:00A M AUGUST /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** HOSPICE OF QUEEN ANNE'S, QUEEN ANNE'S CENTREVILLE INC. Date of Birth (Month, Day, Year) 7/7/1943 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1**X** M 2 □ F 266-66-3190 65 MD **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~~ " any illury or other traumatic event." 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 X Yes 2 ☐ No KENT MD CHESTERTOWN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 400 HADAWAY DR. 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 XNo Specify 2 Specify: 3 Widowed 4 Divorced 61 - 64WHITE Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 MECHANIC AUTOMOBILE REPAIR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ HOWARD ELBERT SHAFFER KATHERINE SOPHIA NICHOLAS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2011 ROBERTS STATION RD. CHURCH HILL, MD 21623 GRACE MORRIS/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) CHESAPEAKE CREAMTION: 8/5/2008 STEVENSVILLE, MD 21. Signature of Funeral Service L 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME uk 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part 1. Enter the disease, or companies shock, or heart failure. List only Approximate
Interval Between
Onset and Death cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest the cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions ner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed burial-transit Exami Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 3 Probably 4 Unknown 1 Tes page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 □ Yes 2 🗔 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 ☐ Other (Specify) Certification: To After this 27. May er of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending n 24 hours after death.
e Funeral Director: At 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. 29b. Signature and alte of 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) JoenHL 31. Date filed (Month, Day, Year) 32. Regis State AUG 8 Registrar

State of Maryland / Department of Health and Mental Hygien 2008

Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Saniah Nyke1 Scott August 4, 2008 11:49 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, August 3, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 ☐ M 2 € x F 0 **Director** Maryland None Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits 1 ☐ Yes 2XX No Directo Maryland Prince George's Brandywine 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20613 14242 Brandwine Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2XX If Yes, Give Year or Dates: Never Married 2 Married 2\1 No Black 1 ☐ Yes 2XXNo Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Whitney Scott Dominique LaToya Douglas Shannon ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dominique LaToya Douglas / Mother 14242 Brandywine Road Brandywine, Maryland 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 08/09/2008 Kalas Crematory Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura Funeral Service License 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part /Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician EXTREME PREMATURIT /Medical Due to (or as a consequence of) Examiner 37 HRS PULMONARY HEMOURHIACE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed DISTRESS SANDROMB RESPIRATORY the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s autopsy performed 2 X NO Hospital or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 XXVatural : after death.
I Director: / 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours and
To the Funeral Dir 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 90054786 NEONatologist 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Who Pegay, Moranh 1500 Forest 23a) (Type, Print) Forstfilen Rd, Silver Spring, MD 20910. 31. Date filed (Month, Day, Year)

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Registrar

AUG 1 1 2008

32. Registrar's Signature

December 1   Dec			For State Registrar	State	of Ma	arylan	•	artmer <i>rtifica</i> i				fental Hy	giene Reg. No	200	8 27	284
Francois Hyaccinthe Souverain  Francois Provided Source and Source Sourc	2 4			e, Last)										Vear		of Death
Manifestion Advantist Hospital			Francois Hyaci	the Souv	era	in						8,	/3/2	008		РМ
South Security Numbers   2.5 doi: 10.5 to 10.5	ົງ Examine	er		. 3	,			4b. City,	Town, or	Location	of Death		4c	. County of Dea	ath	
STAR-07-6022   Total Residence   Total Residen	7						ant hiethelass)				24 Hrs	9 Date of Bi				or Foreign
Description of the property in the College of the				1⊠M 2□ F	/ Age		• • • • • • • • • • • • • • • • • • • •					(Month, D	ay, Year)	9. 6	country)	
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The state of the s	ryland how		10a. State 10b. County			10c. City	, Town or Lo	cation								•
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The state of the s	iff the		10e. Street and Number					10f. Zij	Code				10g. Ci	tizen of What C	ountry?	
The state of the s	s 23a	<u>ra</u>	<del></del>													
August Southerain  J. Christiane Souverain/wife  J. Christiane Sou	ler de	ğ		Armed I	Forces?		5. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Or ın, Mexica	rigin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	)-			
August Southerain  J. Christiane Souverain/wife  J. Christiane Sou	Irs aff			If Yes, C	aive			1 □ Yes	2 🔀 No	Specify.	:			Specify:	Black	
August Southerain  J. Christiane Souverain/wife  J. Christiane Sou	2 hou		15. Deceden	's Education			16a. Dece	dent's Usu	al Occupa	ation			16b. K			
August Southerain  J. Christiane Souverain/wife  J. Christiane Sou	A thin 7	e e		1	·	+)	(Give life. L	kind of wo DO NOT u	rk done d se retired	<i>luring m</i> os I)	st of works	ng				
August Southerain  J. Christiane Souverain/wife  J. Christiane Sou	A de wife set with the set the table to tab	ទូ			`			Jan	itor						ernment	
August Southerain  J. Christiane Souverain/wife  J. Christiane Sou	tal H d oth even	Be												Surname)		
J. Christiane Souverain/wife   3504 Lancer Drive, Hystrsv111e, MD 20782    Quantified Deposition   Comment of Comment   Commen	y 12	2														
Physician Modical Examinor  Ph	With and Tip is in the and Tip	П			/: 6			-								
Physician Modical Examinor  Ph	1 and 1 and Heal Heal term 2	1		ouverain	/WII											
Physician Modical Examinor  Ph	ages ent of it: If it		1 ☑ Burial 2 ☐ Cremation		n State						8/16	5/2008		ıp-Perri		
Physician Modical Examinor  Ph	nit. Prartmet ortan	1				barr				1		7, 2000	47		imore A	Venue
Physician Modical Examinor  Ph	De la	-	1 Juno	AR							-	e, P.A.				
Physician Medical Examinor		23a. Part 1. Enter the disease, or	complications that	caused	the death									Approxima	te	
Due to (or as a consequence of):    Security   Security	Physician		Immediate Cause (Final	My one cause on	2 A	N ()	11/12	. 1	Mr.	HOG	INA	Can	CA	R		
Due to (or as a consequence of):	1			Due to	o (or as a	consequ	ence of):		007	2717 94	7//	-///			0 // (1/	V///S_
Due to (or as a consequence of):    State   Constitution   Constit			Sequentially list conditions	b												
FEMALE   23b. Was decedent pregnant   1   Live birth   2   Fetal death   4   Deregnant at time of death   5   Other (specify)   Month   Day   Year   4   Deregnant at time of death   5   Other (specify)   Month   Day   Year   4   Deregnant at time of death   5   Other (specify)   Month   Day   Year   4   Deregnant at time of death   5   Other (specify)   Month   Day   Year   4   Deregnant at time of death   5   Other (specify)   Month   Day   Year   4   Deregnant at time of death   5   Other (specify)   Month   Day   Year   4   Deregnant at time of death   5   Other (specify)   Month   Day   Year   4   Deregnant at time of death   5   Other (specify)   Month   Day   Year   4   Deregnant at time of death   5   Other (specify)   Month   Day   Year   4   Deregnant   1   Der	bed isit	e l	if any, leading to immediate cause. Enter Underlying	Due to	o (or as a	consequ	ence of):									
FEMALE   23b. Was decedent pregnant   1   Live birth   2   Fetal death   4   Deregnant at time of death   5   Other (specify)   Month   Day   Year   4   Deregnant at time of death   5   Other (specify)   Month   Day   Year   4   Deregnant at time of death   5   Other (specify)   Month   Day   Year   4   Deregnant at time of death   5   Other (specify)   Month   Day   Year   4   Deregnant at time of death   5   Other (specify)   Month   Day   Year   4   Deregnant at time of death   5   Other (specify)   Month   Day   Year   4   Deregnant at time of death   5   Other (specify)   Month   Day   Year   4   Deregnant at time of death   5   Other (specify)   Month   Day   Year   4   Deregnant at time of death   5   Other (specify)   Month   Day   Year   4   Deregnant   1   Der	execur and al-trar	Xan	that initiated events	c	o (or as a	consegu	ence of):								-	
25. Was case referred to medical examiner?    25. Was case referred to medical examiner?   26. Place of Death (Check only one)	e be e	<u></u>		d		,	•									
25. Was case referred to medical examiner?    25. Was case referred to medical examiner?   26. Place of Death (Check only one)	tifficat ig phy as the	ed		u												
25. Was case referred to medical examiner?    25. Was case referred to medical examiner?   26. Place of Death (Check only one)	h cer endin		23b. Was decedent pregnant					Terrir :						23d. Date of de	elivery	
25. Was case referred to medical examiner?    25. Was case referred to medical examiner?   26. Place of Death (Check only one)	deat deat aft ed for	Cig	1 ☐ Yes 2 ☐ No	4 ☐ Pre	gnant at					/				Month	Day	Year
25. Was case referred to medical examiner?    25. Was case referred to medical examiner?   26. Place of Death (Check only one)	at the d by the stacking	ڄَ														
25. Was case referred to medical examiner?    25. Was case referred to medical examiner?   26. Place of Death (Check only one)	res th	2	Part II. Other significant condition	ns contributing to	death bu	t not resu	Iting in the ur	nderlying o	ause give	en in Part I	l.					
25. Was case referred to medical examiner?    25. Was case referred to medical examiner?   26. Place of Death (Check only one)	requi	ered										10	Yes 2	M 140 3 1	Probably 4 🗆	Unknown
25. Was case referred to medical examiner?    25. Was case referred to medical examiner?   26. Place of Death (Check only one)	e law has t	E I										auto	psy	prior to	completion of	available cause of
27. Manner of Death   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   28	i: The ficate r. pag														s 2 No	
and manner stated.  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month, Day, Year)  32. Registrar's Signature	siclar certi recto	ם	examiner?	Hospital:	<i>.</i>				Othe	ar:						
and manner stated.  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month, Day, Year)  32. Registrar's Signature	Phy graffis			1,2						4 🗀 14					ecify)	
and manner stated.  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month, Day, Year)  32. Registrar's Signature	th. : Afte			(Mo			Injury					2001.00	non nga	, y cocumou		
and manner stated.  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month, Day, Year)  32. Registrar's Signature	Atter or dea ector by the	2	3 ☐ Suicide 6 ☐ Could r	ned 28e. Plac	e of Inju	ry - At hor	me, farm, stre	eet, factory	, office						Rural Route Nur	mber,
and manner stated.  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month, Day, Year)  32. Registrar's Signature	s affe	5	4 E Homicide	DUII	uing, etc.	. (Зреспу	,					City or 10	wn, State	e <i>)</i>		
and manner stated.  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month, Day, Year)  32. Registrar's Signature	Hospit 24 hour Funer tely fill		(Check only 2 Medical)	Examiner: On the	basis of	examinat	vledge, death ion and/or in	n occurred vestigation	at the tin	ne, date a pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s	s) and manner a d place, and du	as stated. ue to the cause(	s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month, Day, Year)  32. Registrar's Signature	o the or the or the or the or the or the	_	0116)	and ma	nner stat	iea.	\									
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	F \$ F 5		) WILL	<i>\psi\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ </i>		MX	-		4/>	15			1	3.5.0	8	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		-	30. Name and address of person	who completed car	use of de	ath (Item	23a) (Type, I	Print)	201	Cin	EEN	BFIX	R	MAN	1/ 42	}
	W C		CHITRA VA	WAAR.	AMA	2N 1	no,	C	DAAA	SEE		PRIK	N	D 20	240	
	State Registra		31. Date filed (Month, Day, Year) AUG 1 1 2008	32.	Registra	r's Signat	ure								, -	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** SHRIVER 1017 OBERT VINCENT 2008 AUGUST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 3, 1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 232-28-2283 88 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17508 York Road 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 X Yes 2 If Yes, Give 1 ☐ Never Married 2 Married 2 🗌 No 1 ☐ Yes 2 🖾 No Specify. þ Specify: white 3 Widowed 4 Divorced Year or Dates: WW II Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien. Important: If item 27 is marked other the any injury or other traumatic event, Italy once. 12 brakeman/flagman railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Peter Shriver Jessie Michael 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Meda M. Shriver - wife 17508 York Road, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Spohr's Crossroad Cem. 8/15/08 Berkeley Springs, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHERUSCLEROTIC **Physician** HE ART DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Sequentially list conditions Examiner Due to (or as a consequence of) If any, leading to influed a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>}</u> MITRAL REGURGITATION 1 ☐ Yes 2 ☑ O 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2. No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 ☐ Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician: The law requires that the death certificate be executed burial-tran Box 68760 attending physician for use as the buria P.O. signed by t t be detach Records, page 2 s has certificate of Vital Division Hospital or Attending 4 hours after death. •uneral Director: A ely filled in by the fu 24 hours a Funeral C sompletely within 2

28a-f show

23a or

items

Po,

"natural",

I Hygiene.

Examiner

72 hours after

Baltimore, Maryland 21215-0036

traumatic event, the Medical Exercity count by notified at

05H-0

Medical

State

Registrar DHMH 17 Rev 1/2001 29a. Certifier

(Check only one)

29b. Signature and J

31. Date filed (Month, Day, Year)

AUG 1 3 2008

e of



and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 💢 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0061411

(AMPUS RD, STEISO

29d. Date signed (Month, Day, Year)

HAGERSTOWN MD21742

		-	For State Registrar	ate of Maryland		rtment of H rtificate of L		Re	eg. No. 2 U L	9	27286	
	Physicia		1. Decedent's Name (First, Middle, Last)  JOSEPH J. STA	SHICK				2. Date of Death Month Aug. 6,		Year	3. Time of Death 5:40 P M	
	/Medic Examin		4a. Facility Name (If not institution, give street 4821 Quimby Ave.	and number)		4b. City, Town, or Beltsv	Location of Death		4c. County o		eorge's	
	Funeral Director		5. Social Security Number 173–30–6977 6. Sex	7. Age (In yrs. la	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Morth, Day, April 6	9. Birt 7938 Pen		lace (State or Foreign sylvania	
Maryland 21215-0036	e Maryland a-f show	ctor	Usual Residence of Decedent  10a. State    10b. County   10c. City, Town or Location   10d. Inside City Limits   10d. State   10d. City   10d. Inside City Limits   10d. State   10d. Inside City Limits   10d. Inside City Limits									
	with the 3a or 28 It be not	I Dire	10e. Street and Number 4821 Quimby Avenue			10f. Zip Code 2070	)5	10	og. Citizen of W Unite			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinat must be notified at once.	by Funeral Director	11. Marital Status 12. W	ias Decedent Ever in U.S med Forces? MYes 2 Mo Yes, Give 1957-19 ear or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2ሺ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black Specify:	, White,	ean Indian, etc. White	
	within 72 hor iene. than "naturi in Moicell	To Be Completed by	15. Decedent's Education (Specify only highest grade com Elementary/Secondary 10-12)	pleted)	16a. Dece (Give life.	dent's Usual Occup kind of work done of DO NOT use retired er Servic	ation during most of work the Fnoine	ing er	16b. Kind of Bus			
	be filed wintal Hygier Ad other the event, the		17. Father's Name (First, Middle, Last)  Joseph George Stashio		Compac	CI DCIVIC	18. Mother's Name Anna Hel	e (First, Middle, N	Maiden Surname			
	nd 2 should lith and Me 27 is mark r traumatic		19a. Informant's Name/Relationship (Type. P. Anthony D. Stashick	rint)	19b. Mailin 5747	ng Address (Street: Moonbeam	and Number or Rui Drive Wo	al Route Number odbridge	; City or Town,	State, Zip nia	22193	
Baltimore,	Pages 1 ar nent of Hea int: If item 3		20a. Method of Disposition  f ☐ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	20b. Pl		sition (Name of natory or other place terans Ceme			20c. Location - Cheltenha	•		
Balti	permit. Departm Importa any Inju		21. Signature of Funeral Service Licensee	Shows	2: 4.2	Name and Addre Onald V. OO Powde	ss of Facility Borgward Mill Ro	t Funera ad Belts	l Home, sville,	PA Mary	land 20705	
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  Myocardial Infarction  Approximate Interval Between Onset and Death Acute									
ď	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):							
	executed and al-transit	Examiner	Sequentially list conditions, if any, leading to immediate causs. Linter underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):									
68760,	ficate be executed physician and s the burial-transit	edical E	d									
of Vital Records, P.O. Box 6	ath certi attending for use a	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1							23d. Date of delivery Month Day Year		
	uires that the de signed by the Id be detached	δ	Hyportonsion: Phonmatoid Arthritis									
	The law requir cate has been single 2 should I	Completed	24							24b. Were autopsy findings availa prior to completion of cause of death?  1 □ Yes 2 🕅 No		
Vita	yslcfan; is certific director,	æ	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospi	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home							ify)	
	ding Phys th. : After this funeral di	tion: To	Address of the Park of the Par	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred								
Division	al or Attending s after death. I Director: After d in by the funer	Medical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or I within 24 hours after To the Funeral Dire											
	To the within To the comple	Me	29b. Signature and title of certifier		29c. Licen:			29d. Date signe				
	20+1		30. Name and address of person who complete	eted cause of death (Iten	n 23a) (Tvpe	D249	9/		Augus	st /	, 2008	
			Luis A. Casas, MD	8317 Cherry	La. I		d. 20707					
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	K A	mente						

08-06105 John Robert Short Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

in Robert She		State of Maryland / 1- For State Registrar	Certificate	t of Health and Mental H e of Death	rygierie Reg.	No. 200	18 2728				
Physici	an/	Decedent's Name (First, Middle,Last)			2. Date of Death		3. Time of Death				
dical Exami	ner	John Robert Short			Month I August 10,	2008 4c. County of Death	0551 hrs				
		4a. Facility Name (if not institution, give street and number) East Bound 50, Bay Bridge 36.1 MM		4b. City, Town, or Location of Death Stevensville	1	Queen Anne's					
Funeral		5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday		_	(MM/DD/YYYY) 9. Birt					
Director		229-72-3413 1XM 2 F	57	Yrs. Months Days Hours Mir	11/23/	1950 Foreig	untry) VA				
any		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits				
≱ .		MD Wicomico	Willar				1 Yes 2 X No				
arylan 8a-f sl	Director	10e. Street and Number	WITIU	10f. Zip Code	10g	. Citizen of What Cour	itry?				
vith the Maryland s 23a or 28a-f show s e.notified at once.		35707 Old Ocean City Rd.		21874		USA					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	eral	11. Marital Status 1 Never Married 2 X Married Armed Forces?		. Was Decedent of Hispanic Origin? (S		14. Race - Ameri White, etc.	can Indian, Black,				
er deat , or it	Fun	I Never Married 2 A Married To	No	Yes 2 X No specify:	. ,	Specify: Wh	ite				
urs aft tural"	d by	15. Decedent's Education (Specify only highest grade com	npleted) 16a. Dec	edent's Usual Occupation (Give kind of		16b. Kind of Business/I					
6 72 ho an "na cal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5	5+)	ng most of working life. DO NOT use re							
003 within giene.	omp	12 17. Father's Name (First, Middle, Last)	Tru	ck Driver		Trucking D	istributor				
21215-0036 uld be filed within 72 Mental Hygiene. marked other than '	Be C	Lloyd R. Short		Beula E.	e (First, Middle, Ma Musser	alden Surname)					
21; ould b d Men s marl	To E	19a. Informant's Name/Relationship (Type, Print )	1	ailing Address (Street and Number or	Rural Route Numb						
MD and 2 sho alth and 2 sire 27 is		Connie M. Short / wife  20a. Method of Disposition		707 Old Ocean City sposition (Name of cemetery, T		11ards, MD					
Baltimore, permit. Pages 1 ar Department of Her Important: If ite		1 Burial 2 X Cremation 3 Removal from Sta	ate crematory	or other place)							
Itim it. Pag rtment ortant:		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee /		enlopen Crem. 8/		Frankford					
Balt permit. Depart Import injury		WM Wackerel		108 William St		Funeral Ho MD 21811	me				
Physician		23a/Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death. Do not er				Approximate Interval Between Onset and				
∲Medical xaminer		Immediate Cause (Final disease a. Multiple Injuries and Drowning									
		h	equence of):								
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	equence of):								
-	Examin	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
cecuted n and r transit	al E	d.									
60, ate be exe obysician a	Medical	UNPENDED AMENDED									
Division of Vital Records, P.O. Box 68760, To the Itospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	M/u	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcor	me of pregnancy	Fetal death 3 Ectopic pregr	nancy	23d. Date of deliver Month	y Day Year				
Box 687( ne death certifica r the attending phe	Physician/	4 Pregnant at	time of death 5	Other (Specify)							
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of Vital Records, P.O. ing Physician: The law requires that the three this certificate has been signed by the thin thin thin thin thin thin thin thin	d by				1 Yes	2 No 3 Pro	bably 4 🗸 Unknown				
ords, w requir is been s should	Completed				24a. Was a autops		utopsy findings available completion of cause of				
Recc The lay ate has	omp				perform	ned? death?					
tal Recicion: The certificate	Be C	25. Was case referred to medical examiner?		26.Place of Death (Chec	k only one)						
FVil Physic er this	Tol	1 V Yes 2 No Hospital: 1 Inpatie 27. Manner of Death 28a. Date of Inju	ent 2 ER/Outpa	e of Injury 28c. Injury at Work?		Residence 6  Othe	r: Scene				
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Division tal or Attendir rs after death.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of In	njury - At home, farm	, street, factory, office building, etc.	28f. Location (S	treet and Number or Ri	ural Route Number, City				
Div spital o tours af	Serti	4 Homicide determined (Specify) Ma	ijor Road / High	way	or Town, St East Bound 50	ate) , Bay Bridge 36.1Ml	M, Stevensville, MD				
To the Hos within 24 h To the Fun		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)  (Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
To the within To the comp	Medical	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mo					
	1456	-11 11 11 i -	~		DCME	August 10, 2008					
<del></del>		30. Name and address of person who completed cause of c	death (Item 23a)	<u> </u>							
10+1			ledical Examine	er 111 Penn Street, Baltimo	ore, MD 21201						
S Regis	tate	31. Date filed (Month, Day, Year) 32. Register	r's Signature	(hadi)							

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

			1 - For State Registrar  1. Decedent's Name (First, Middle, Lasi	State of Maryland	•	tificate of L			Reg. No.	0000	3. Time of Death
	Physic /Medi Exami	cal	Eli 7abeth  4a. Facility Name (If not institution, give	ANN	Si	hoemake, 4b. City, Town, or	Location of Death	Month August	Day	Year 2006 County of Deat	- 1732 PM
	Exami	iei	The Johns Hopkins Ho			Baltimore	Citv				
	Funeral Director		5. Social Security Number 6. Se	-	ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt 5-23-1	990	9. Bin	thplace (State or Foreign
Maryland	Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	tor	Usual Residence of Decedent  10a. State 10b. County  DELAWARE SUSSEX	,	, Town or Lo						10d. Inside City Limits  12 Yes 2 No
h with the		Funeral Director	10e. Street and Number 835 GLEN DRIVE		10f. Zip-Code 19930			10g. Citizen of What		izen of What Co	l untry?
U. Z. I. Z. I. SCOSO fled within 72 hours after death with the Maryland	al", or items Examiner mu	by	11. Marital Status  1 🛣 Never Married 2 🗌 Married 3 🗎 Widowed 4 🗎 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 No	lispanic Ongin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify:	
Z   Z   3-0030 d within 72 hours aft	"natur edical i	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	(Give	lent's Usual Occup kind of work done OO NOT use retired	during most of work	ing	16b. K	and of Business	/Industry
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Maryland d 2 should be file	dental Hy rked oth	To Be	17. Father's Name (First, Middle, Last) GLENN SHOEMAKER	18. Mother's Name (First, Mic ROSANNE SOT.							
, IVICAL ) and 2 sho	ealth and h		19a. Informant's Name/Relationship (7 GLENN SHOEMAKER/F.		19b. Mailir 835 G	ng Address (Street LEN DR,	and Number or Rui BETHANY B	EACH, D	er, City o ELAV	VARE. 19	Zip Code) 9930
<b>SAITIMOFE,</b> Dermit. Pages 1 a	rtment of He rtant: If item njury or oth		20a. Method of Disposition  1 X Burial 2 Cremation 3 4 Donation 5 Sther Society  21. Signature of Funeral Service Licens	Removal from State CRE	STETEL AW ORIAL	sition (Name of patory or other place GARDENS	8-14-		MAR	ocation - City or	Town, State  ILLE, MD
Da	Depar Impor any Ir		21. Signature of Parity 21 Service License	Adsor	MÉ WE	LSON FUN ST AVENU	ess of Facility ERAL SERV E, OCEAN	ICES,LT VIEW, D	D. ELAV	VARE. 19	9970
	the law requires that the death certificate be executed by Manager 2 should be detached for use as the burial-transit		23a. Pad 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	Sepsis	. Do not ent						Approximate Interval Between Onset and Death
			resulting in death)  Due t (or as a consequence of):  Nutropunia							months	
scuted		Examiner	Sequentially list conditions, if any, leading to immediate cause. Each Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as consequence)  Leikemia  Due to (or as a consequence)							years
os/ou, ificate be ex		fedical E	Comming and county and	.d	201100 017.						
J. DOX O		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	□ Ectopic pregnancy □ Other (specify)				23d. Date of delivery Month Day Year			
uires that the		by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
The law requires to	te has been signe bage 2 should be	Completed						24a. Was autor perfo 1 Yes		prior to death?	
	rtifica ctor, p	Be	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only o	пө)		
OI VILAI	nis ce al dire	₽	1 □ Yes 2 No	/ / ·	ER/Outpatien		4 🗆 Ivarsing no			6 Other (Spe	ocify)
or Attending P	To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page	Certification:	27. Manner of Death   1 Natural   5 Pending   2 Accident   3 Suicide   6 Could not be		28b. Time o Injury	M 1 🗆	ry at k? Yes 2 □ No	28d. Describe			
tai or Att		Certifi	4 Homicide determined	eet, factory, office	City or Town, State)						
e Hospi		Medical								as stated. ue to the cause(s)	
e E	To th Comp	Me	29b. Signature apolitile of certifier	MD		29c. Licens	e number			ite signed (Moni	
A	H2		30. Name and address of person who Chris Yang	completed cause of death (Iten	n 23a) (Type,	Print)	600	North Wo	lfe S	St, Baltim	ore, MD, 2128
		ate	31. Date filed (Month, Day, Year) AUG 1 1 2	32. Registrar's Signat		barte					
DUL	J 47 Day 47	2004	AUG I I Z	James .	er for	The state of the s					

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Bay **Physician** Aua 2008 0630 1 THOMAS PAUL STERLING /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisburg Wicomico RehabaNursingCtr disbura If Under 1 Year | If Under 24 Hrs. Date of Birth
(Month, Day, Year
NOV • 29 , 1 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. test birthday **Funeral** 1931 Maryland Months 1 M 2 □ F 76 Director 220-32-9980 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1√ Yes 2 No Directo Maryland Pocomoke City Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 21851 Funeral 302 Market Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. should be filed within 72 hours after ond Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No White Specify Specify: Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Seafood Processing Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Menta Grace Blake Willis Sterling ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 item 27 i 24962 Collins Wharf Road - Eden, MD 21822 Barbara Mister (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Aug. 12, 2008 | Crisfield, Maryland Asbury Cemetery 21. Signature of Funery Service Toensed

Many Beth Bradshaw-Pruitt

22. Name and Address of Facility BRADSHAW & Some Service Toensed

306 W. Main Street - Crisfic Street - Crisfic Shock, or heart failure. List only one cause or each line. 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, MD 21817 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pas disease or condition resulting in death) /Medical Due war as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the as led by the attending detached for use as IF FEMALE use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) o. 9 Unknown or Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signe should be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy perform Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1€ No 3□ DOA 1 Inpatient 2 ER/Outpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner Death 28h Time of 28d. Describe how injury occurred or Attending 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident neral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide after Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

within 24 hours at To the Funeral Completely filled i

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32. Regist AUG 1 2 2008

20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Robins

29c. License number

ue. Salisbury

			For State Registrar		State of	of Mar	yland / D	•	rtment			nd Me		giene Reg. No.	008	272	90
			Decedent's Name (First,	, Middle, Las	t)								2. Date of De	ath		3. Time of De	ath
	Physicia /Medic		Flora	A. So	cott								Month Augus	Day + 15	Year 200	8 6:55	Рм
)	Examin		4a. Facility Name (If not ins	stitution, give	street and nu						Location of I		1149.40	4c. Co	unty of Dear	th	
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	Funeral Director		5. Social Security Number 233–10–7461		x □ M 2€3€	7. Age 10	In yrs. last birt	hday)_ (rs.	If Under Months	Days	If Under 24 Hours		8. Date of Bir (Month, Da 3 / 22 /	th 19. Year) 1908	9. Bin Co	thplace (State or Fountry) VA	Foreign
	and w		Usual Residence of Deced	ent County			IOc. City, Town	or Loc	ation			-				10d. Inside City I	Limits
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	the 1	Director	10e. Street and Number	ti i Oi c					10f. Zip					10g. Citizen	of What Co	ountry?	
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	deetl	Funeral	11. Marital Status		12. Was Dec		er in U.S.	13. W	as Decede	ent of Hi	spanic Origin	n? (Spec	cify Yes or No lican, etc.)	p- 14.	Race - Ame Black, Whit	erican Indian,	
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Division of Vital Records,	i or Atte efter de Directo d in by th	ertific	3 Suicide 6 4 Homicide	Could not be determined	286. Plac	ce of Injur ding, etc.	y - At home, fa (Specify)	rm, stre	eet, factory	, office		2		(Street and Nown, State)	Vum <i>ber</i> or F	iural Route Numbe	er,
	To the Hospital or Attending Is within 24 hours efter death. To the Funeral Director: Atter completely filled in by the funer	edical C	29a. Certifier 1 0 C (Check only 2 M	Certifying Ph ledical Exan	niner: On the	ne best of basis of e	my knowledge examination an	death	occurred restigation,	at the tin	ne, date and pinion, death	place, a	and due to the	cause(s) and, date and pl	nd manner a ace, and du	is stated. e to the cause(s)	
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	5		30. Name and address of	person who	Completed ca	e A	ath (Item 23a)	(Type, i	Print)	TW.	n P.S.	5111	6 inc	- t=41	( c + p + p + p + p + p + p + p + p + p +	MO 2104	9 179
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** THOMPSON TANGERLINETT 7:30 Α 2008 AUGUST 6 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE"S CLINTON NURSING HOME & Rehab. CLINTON Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 1 F 31 229-13-3681 1 1977 WASHINGTON, DC Director APRIL Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f element injury or other traumatic event, the Medical Control once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 XYes 2 No WOODBRIDGE Director PRINCE WILLIAMS VA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 22191 2554 MIRANDA COURT Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? Black, White, etc 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married BLACK 1 ☐ Yes 2 🗷 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE HOME MAKER 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, THOMPSON LILLIAN TIMOTHY SHAW ၉ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2554 MIRANDA COURT WOODBRIDGE, VIRGINIA FELIX K. NKANSAH /HUSBAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State RIVERDALE CREMATORY 8/8/2008 RIVERDALE, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Function Solvice 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician END STAGE AIDS disease or condition resulting in death) /Medical Due to (or es a consequence of): Examiner MALNUTRITION Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed URINARY TRACK INFECTION and the burial-trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2√2 No certificate 1 □Yes 25 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 🙀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident completely filled in by the 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

P.O. Box 68760. Division of Vital Records, 24 hours a

within 2 State Registrar

29b. Signature and title of certifig

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D25640

29d. Date signed (Month, Day, Year)

AUGUST 7, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KHOSROW DAVACHI M.D. 7801 OLD BRANCH AVENUE # 409 CLINTON, MARYLAND 20735

31. Date filed (Month, Day, Year) AUG 0 8 2008

29a, Certifier (Check only one)



State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 8 Ruth Timmons 8 2008 7:35 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Snow Hill Nursing Home Snow Hill Worcester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 8/23/1919 Days 1 ☐ M 2 💢 F 88 156-01-0164 ٧A Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 ☑ No MD Director Worcester Snow Hill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 100 Burrough St. 21863 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Completed by 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be file and Mental H Be Joseph Matthew Whetzel Nina Hollinsworth ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an ant: If item 27 is I ury or other trau Otho Mariner 5831 Disharoon Rd., Snow Hill, MD 21863 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury o Old School Baptist Cem 8/12/2008 | 4 ☐ Donation 5 ☐ Other (Specify) Snow Hill, MD 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 mesa death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the alsease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final A CUTE KENAL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, nding physician use as the burial Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ZNo Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has irector, page 2 perform 1∐ Yes 2 No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director; After the completely filled in by the funeral. 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie M.D. 8005/11/8 0 62172 Name and address of person who completed cause of death (Item 23a) (Type, Print) SATYAL, M.D. 1604 MARKET ST. POCOMOKE GIY MD 21851. SHARAD R. 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 2 2008 Registrar

08-06176 UNK UNK Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

K UN	IK	1	State of Maryland / Depart	tment of ificate of	Health and Death	Mental Hy	giene Reg.		108 2729	
y ~	Physicia Examir	n/	legistrar  1. Decedent's Name (First, Middle, Last)  Paul Richard Woods, J	r.			2. Date of Death Month D August 12, 2	eay Year 2008	3. Time of Death 1827 hrs	
	_Adiiii		4a. Facility Name (if not institution, give street and number) 9404 Falls Road	4	b. City, Town, or Lo Potomac	ocation of Death	,	4c. County of Deat Montgomery	h	
	Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. las		Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth(	MM/DD/YYYY) 9. Bi Fore	rthplace (State or ign ountry)New York	
	ŕ	ļ	Usual Residence of Decedent  10a. State 10b. County 10c. City, T	Fown or Location					10d. Inside City Limits	
		ector	10e. Street and Number	erling	10f. Zip Code		US	j. Citizen of What Co	1 Yes 2 X No untry?	
	should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	eral Di	47379 McCarthys Island Ct.  11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?	5. 13. Wa	20165 as Decedent of Hispa es, specify Cuban, I	anic Origin? ( Sp Mexican, Puerto	ecify Yes or No-			
	urs after dea tural", or i	d by Fune	3 Widowed 4 Divorced If Yes, Give Year	16a Deceden	Yes 2 X No nt's Usual Occupation nost of working life. I	on (Give kind of v		Specify: W 16b. Kind of Busines	hite s/Industry	
9036	vithin 72 ho ene. er than "na Medical Ex	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)		Shop Manag	ger	e (First, Middle, M	Auto Body	Shop	
21215-0036	ld be filed v Aental Hygi narked oth event, the	S	17. Father's Name (First, Middle, Last)  Paul Richard Woods  19a. Informant's Name/Relationship (Type, Print )	19b. Mailin		Alice H	lughes	per, City or Town, Sta	ate, Zip Code)	
e, MD 2	permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	F	Susan W. Woods/Wife 47379 McCarthys Island Ct., Sterling, Va 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Money & King Cremation 8/18/08 Chantilly,							
Itimore	nit. Pages lartment of lortant: If		1 Burial 2 X Cremation 3 Removal from State Moï 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses	Service 22.	CES Name and Address	of Facility	1000	171 V	V. Va.20151 V. Maple Ave.	
Ba	vsician		M00968  23a. Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.	. Do not enter	the mode of dying,	such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death	
E	/ledical xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Drowning asso Due to (or as a consequence or		l with tra	azadone	& alcoho	ol intoxio	cation	
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated							
	executed an and al - transit	dical Exa	events resulting in death) Last  Due to (or as a consequence of d.		23a,PII,	27,28a-1	, per M	E G883 9/	17/08 TT	
8760.	E. C. 6	sician/Medic	A UNPENDED	gnancy	Fetal death 3			23d. Date of deli Month		
Box 68760			1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not	3(	Other (Specify)	given in Part I.	23e. Did to	obacco use contribut	e to the cause of death?	
О В	w requires that the d s been signed by the should be detached	<u>غ</u>	Atherosclerotic cardiovascu				24a. Was	an 24b. Wer	Probably 4 Unknown  The autopsy findings available in to completion of cause of	
of Vital Records	The law recate has be page 2 sho	1 7			00 8100	e of Death (Chec	1 🗸 Yes	ormed? dea		
Vital	fing Physician: The l After this certificate I funeral director, page	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatie	ent 3 DOA	0.0	sing Home 5	Residence 6 🗸 0	Other: Scene	
) o acieivio	Attending I death ector: Afte	Cortification:	27. Manner of Death  1 Natural 2 Accident  Natural 5 Pending Investigation X Pending Investigation 2 Replace of Injury (Month, Day, Year)  Fnd 8/12/08  28e. Place of Injury - At	Fnd 6	:27 pm 1	Yes 2 XNo building, etc.	unknown 28f. Location		or Rural Route Number, City	
	LOINING  JONISHOT  Josephial or Attend  hours after death  uneral Director:			d in r	curred at the time.	date and place, a	nd due to the cau	use(s) and manner as	s stated.	
	To the Hos within 24 h To the Fun	Modical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.  29b. Signature and title of certifier	and/or investi	igation, in my opinio	n, death occurre	d at the time, date	29d. Date signed	(Month, Day, Year)	
			30. Name and address of person who completed cause of death (Ite	em 23a)		.M.E.		August 13, 2		
		Staf	Ling Li, MD Assistant Medical Examiner 11	11 Penn Str	reet, Baltimore	, MD 21201				
	Reg		AUG 2 5 2008   See 1	15 16						

DHMH 17 Rev 1/2001 OCME 2006

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29d. Pate signed (Month, Day, Year)

			Registrar			Cer	uncate c	Dealli		Reg. No.			
	4		1. Decedent's Name (First, Middle, La	st)					2. Date of De		Veer	3. Time of D	eath
	Physici		Lewis Montgome	rv Wimbu	sh				August	6. 20	OO8	4:00	A.M
	/Medic		4a. Facility Name (If not institution, giv		<u> </u>		4h City Towl	n, or Location of D			ounty of Death	1 1.00 1	
4	Examin	er	13855 Solomons Is		C 11						alvert		
<i>.</i>							Solomo		dre   Date of Bi			alana (Ctata ar	Familia
	Funeral Director		220-48-3376	<b>3</b> € M 0□ E	6 (In yrs. Ia	st birthday) Yrs.	Months Da		#in. 8. Date of Bi (Month, Di 09-08-	ay, Year)	Coui	olace (State or i ntry) ginia	roreign
	p ,		Usual Residence of Decedent		10a Cibr	Town or Lo	notion					10d. Inside City	Limite
	hov at	_	10a. State 10b. County  Maryland Calvert			Lomons						1 ☐Yes 2	
	a-f s	cto	maryrand carver	·	30.	LOMOTIS						1 🗆 1 63 2	- 1271140
	should be filed within 72 hours after death with the Maryland ind Mental Hyglene. It marked other than "natural", or items 23a or 28a-f show unatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 13855 Solomons Is	land Road,	C 13	3	10f. Zip Cod 20688			-	en of What Cou	-	
	ins 2 mus	erg	11. Marital Status	12. Was Decedent B	Ever in U.S	3. 13. \	Nas Decedent	of Hispanic Origin	? (Specity Yes or No uerto Rican, etc.)	0- 1-	4. Race - Ameri		
_	ter d	Fu	1 ☐ Never Married 2 X Married	Armed Forces?	₀ 196	:n_			uerto Rican, etc.)	]	Black, White,		
	rs af	þ	3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 □ N If Yes, Give Year or Dates:	198		I∐Yes 2 <b>X</b> ∏I	No Specify:			Specify: Bla	<b>ack</b>	
3	hou tura	D	15. Decedent's E	ducation	150		ient's Usual Oc	cupation		16b. Kin	d of Business/In	dustry	
Ċ	"na edic	Completed	(Specify only highest gr	ade completed)		(Give	kind of work do	ne during most of tired)	working	144		,	
V	vithii ne. han	ᇤ	Elementary/Secondary (0-12)	College (1-4or 5	+)					Com	ırity		
V	lygie lygie it, ih	ပိ				secur	ity Gua		Name (First, Middle				
yland	tal H	To Be	17. Father's Name (First, Middle, Last						, , , , , , , , , , , , , , , , , , , ,	,			
<u>0</u>	uld h Men trke	ပ္	Lewis Montgomery	Jones				Corine	Torry W	ımbusi	n .		
Mary S	1 and 2 Health a Sm 27 is	ľ	19a. Informant's Name/Relationship ( Hon Wimbush (Wife			1			r Rural Route Numi Bowie, Maj			code)	
בר ע			20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of	f I	Date	20c. Loc	ation - City or T	own. State	
5	Pages nent of h ant: If Ite ury or o		1 ☐ Burial 2 XXCremation 3 ☐				sition (Name or natory or other		0 /7 /0000	ľ	-		. • _
Ξ.	Pa men ant: ury		4 ☐ Donation 5 ☐ Other (Speci	<i>fy</i> )	Met	ropol:	ıtan Cr	ematory	8/7/2008	Alex	andria,	Virgir	na
Dallillor	permit. Depart Import any inj		21. Signature of Funeral Service Lice	nsee				ox 600. T	Rausch usby, Mai		ral Home 1 20657	e, P.A.	
	31 15.00		23a Part1 Enter the disease or com	nolications that caused	the death						. 2000.	Approximate	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only							277001,		Interval Betw Onset and De	veen eath
	Physician		Immediate Cause (Final disease or condition	CANC	-52	OF	146170	+-NEC	R		4	23 mc	INT
	/Medical		resulting in death)	Due to (or as	a consequ	ence of):							
	Examiner <sup>.</sup>			b									
	334.50	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequ	ence of):							
	uted I ansit	Examiner	cause. Enter Underlying Cause (Disease or injury									4	
	xecu and	Xa	that initiated events resulting in death) Last	CDue to (or as	a consequ	ence of):							
00/00	be e ician buria												
0	ate hysi the I	iğ F		►d									
0	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	n/Medical	IF FEMALE:										
9	th ce endi	Jug	23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth		ncy death 3F	]Ectopic pregna	ancv		2	3d. Date of deliv		
٥.	death e atten id for u	Cit	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		ath 5	Other (specif)	)			Month	Day Yo	'ear
9	requires that the een signed by the rould be detache	Physicia	9 ☐ Unknown	9□Unknown									
<u> </u>	that led b		Part II. Other significant conditions	contributing to death be	ut not resu	lting in the u	nderlying cause	given in Part I.	23e. Did	tobacco us	se contribute to	the cause of de	eath?
ecords,	sign sign d be	by							16	Yes 2	No 3□Pro	bably 4 U	nknowr
5	request	Completed							_			_	-
D D	a a	bje							— 24a. Wa	s an opsy	24b. Were aut	opsy findings a ompletion of ca	ivailable
C	The ite h	E							per 1⊟ Yes	formed?	death?	2 □ No	
		O	25. Was case referred to medical					26 Place of	Death (Check only		10100		
>	Physician; The la this certificate ha ral director, page 2	o B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Dippatie	nt old	ER/Outnation	nt 3 DOA	Other	ng Home <b>5</b> 2 Res		□Other (C: ::	i6.0	
5	Phy this		27. Manner of Death	28a. Date of Inju		28b. Time o	I 3 DOY	4 LI Nursi	ng Home Rescribe			119)	
	ling Affer uner	on	1ÆNatural 5 ☐ Pending	(Month, Day	y Year)	Injury		Injury at Work?		TIOW IIIJUTY	GOOGLIEU		
VISION	eath or: ,	Sati	2 Accident investigation 3 Suicide 6 Could not be					1 ☐ Yes 2 ☐ No					
5	er d	Ě	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju	ury - At hoi c. <i>(Specify</i>	me, farm, sti ')	eet, factory, off	ice	28f. Location City or To	(Street and own, State)	Number or Ru	al Route Numb	oer,
2	e Hospital or Attending Physis 24 hours after death. e Funeral Director: After this or letely filled in by the funeral dire	Certification:											
	hour hour mer: y fille	ical (		hysician: To the best									
	F. F.	양	(Check only 2 Medical Exa	miner: On the basis of and manner sta		ion and/or in	vestigation, in i	ny opinion, death	occurred at the time	e, date and	place, and due	to the cause(s)	)

dew (et)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STANLEY WATILINS 900 PRST6 ATE NO PANNITOULS MO 21401

29c. License number

# Baltimore, Maryland 21215-0036

Box 68760. P.O. I Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 0510AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESTERTOWN KENT CHESTER RIVER HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 2/15/1919 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex **Funeral** 7. Age (In vrs. last birthday) Months Days Hours Min. 1 X M 2 □ F 89 WV 245-48-6837 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is investing that it is notified a once. 1 ☐ Yes 2 No **Funeral Director** KENT MD WORTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12836 POND CREEK RD. 21678 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐Yes 2X No Specify: ģ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) MEDICAL Elementary/Secondary (0-12) College (1-4or 5+) 12 PHYSICIAN/HOSPITAL ADMINISTRATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ HOMER ALLAN WALKUP, SR. LILLIE BELLE HARRIS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY ROE WALKUP/WIFE 12836 STILL POND CREEK RD. WORTON, MD 21678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREAMTION 8/8/08 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME
130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) asperation /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 □ Yes 2 No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of certifier 16/1lun, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave, Chestestown, Washington 31. Date filed (Month, Day, Year) State Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month 8-4-2008 14:05 PM F. WILLIAMSON ELIZABETH /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ROCKVILLE MONTGOMERY CASEY HOUSE 8. Date of Birth (Month, Day, Year) 11-14-1911 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours Min 1 □ M 2 √2 F 577-58-5994 96 CLARKSBURG, MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1√ Yes 2 No Director MONTGOMERY MD CLARKSBURG 10g. Citizen of What Country? 10e. Street and Number 23400 STRINGTOWN ROAD 20871 S. Α. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 XNo Specify Specify: BLACK ģ 3XXWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STAT CLERK DEPT. OF COMMERCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT PERRY FOREMAN MARTH BROWN ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MARGARET F. WILLIAMS - NIECE 23400 STRINGTOWN RD. CLARKSBURG, MD 20871 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐ Removal from State LINCOLN CEMETERY 8-13-08 BRENTWOOD, MD 22. Name and Address of Facility PINCKNEY-SPANGLER F. H. Service Licensee 524 - 8TH ST., N. E. WASH., DC 20002-5236 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death so not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) GALLBLADDER CANCER Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter a Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of):

**Physician** , /Medical Examiner

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event once.

**Funeral** 

Director

is filed within 72 hours after death with the Maryland al Hygiene.
other than "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

and physician a s the burial-

filled in by the f

The law requires that the death certificate be executed P.O. Records, Division of Vital Hospital or Attending within 24 hours a

Box 68760

12 State Registrar

Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 moni Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2∏X No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. If Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the control of the control o 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature nd title of certifie D0064615 8-4-2008 M

6002 MUNCASTER MILL RD. ROCKVILLE, MD 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

GENEVIEVE WROBLEWSKI, M. D.

31. Date filed (Month, Day, Year)

AUG 0 8 2008

27297

			For State Registrar	State of Wil			ificate of		wierität i ij	Reg. N	10.	C1C31
			1. Decedent's Name (First, Middle,	Last)					2. Date of D		Day Year	3. Time of Death
	Physici /Medio		JOHN WILLIAM	S					AUGUST		4 2008	9:47 P M
1	Examir		4a. Facility Name (If not institution,	give street and number)		4	4b. City, Town, or	Location of Deat	h	- 1	c. County of Deat	
-			6502 PINN OAK C				CLINTO		T = = : .=	1	PRINCE G	
	Funeral Director		240-68-1267	6. Sex 7. Ag 1 ☑ M 2 ☐ F 63	e (In yrs. last birti		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		irth Pay, Yea 1	9. Bir 944 NC	thplace (State or Foreign ountry)
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Loca	ition					10d. Inside City Limits
	Mary a-f sh	ţċ	MD PRINCE	GEORGE'S	CLINTON	I						1 X Yes 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. (	Citizen of What Co	ountry?
	23a unit b	rai	6502 PINN OAK C	OURT			20735			1	USA	
	er dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. Wa	as Decedent of H (e.s., specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or N to Rican, etc.)	0-	14. Race - Ame Black, White	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it with a facility and items.	þ	1 ☐ Never Married 2 💢 Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 Maryes 2 □ 1 If Yes, Give Year or Dates:	No	1[	□Yes 2 <b>X</b> ]No	Specify:			!	LACK
15-	"natu	lete	15. Decedent's (Specify only highest	s Education grade completed)	16a.	Decede	nt's Usual Occup nd of work done	eation during most of wo d)	rking	16b.	Kind of Business	/Industry
12	within iene. <b>than</b> "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	)+)	NAG!		1)		XE	ROX CORP	ORATION
p	il Hygid other rent, t	BeC	17. Father's Name (First, Middle, L	<u> </u>				18. Mother's Na	me (First, Middle			
lar	And be Anta Anta rked tlc ev	To B	JOHN WILLIAMS					ANNIE	PRINCE			
Maryland	2 should be fil and Mental H is marked ot aumatic ever	19	19a. Informant's Name/Relationshi	ip (Type. Print)	19b.	Mailing	Address (Street	and Number or R	ural Route Num	ber, Cit	y or Town, State,	Zip Code)
	1 and 2 sh Health an tem 27 is r	1 8	DELORIS WILLIAM	S / WIFE			PINN OAK		CLINTO	<del></del>		
Baltimore,	ges 1 ar nt of Hea if item		20a. Method of Disposition 1    Burial 2 □ Cremation	3 ☐ Removal from State			tion (Name of tory or other plac	i	Date	20c.	Location - City or	Town, State
tim	permit. Pag Departmen Important: any injury once.		4 ☐ Donation 5 ☐ Other (Sp.		Oak Gr			em. 08-1			rysburg,	NC OME OF MD
Ba	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service L	DONALD	R CRAV			LAND ROA			ONEKAL H AND, MD	20746
			23a. Par 1. Enter the disease rsh ck, or heart failure. Laro		H-11- 1-						and, in	Approximate Interval Between
	Physician		Immediate Cause (Final		<sup>ne.</sup> atic Gas							Onset and Death
	/Medical		disease or condition resulting in death)	a	a consequence o							26 MONTHS
	Examiner		Sequentially list conditions	b. =								
1	pe tis	ine	Sequentially list conditions, if any, leading to immediate cause. Enter United Physics Cause (Disease or injury		a consequence of	of):						
	xecut and Il-tran	Examine	that initiated events resulting in death) Last	c. Due to (or as	a consequence o	if):						
68760,	rtificate be executed ng physician and as the burial-transit					.,,						
687	rtificate ng phy: as the	Medical		d			-				1 .	
.O. Box	Attending Physician: The law requires that the death cer refeath. sctor: After this certificate has been signed by the attendin by the funeral director, page 2 should be detached for use.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death		Ectopic pregnand Other <i>(specify)</i> _	ey .			23d. Date of de Month	elivery Day Year
ъ,	res that igned to be dets	by P	Part II. Other significant condition	ns contributing to death b	ut not resulting in	the und	lerlying cause giv	en in Part I.	23e. Dig	tobacc	co use contribute t	o the cause of death?
bro	w require been si should t								1	]Yes	2 <b>X</b> No 3□ P	Probably 4 🗆 Unknown
of Vital Records,	i: The law r icate has be ; page 2 sh	Completed							24a. Wa aut	opsy	prior to	utopsy findings available completion of cause of
a	sician: The certificate rector, pag								per 1 □ Yes	formed 2 X		s 2□No
Vit	siciar certif	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of De				
ō	Physer this eral di	1:1	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Inju	ent 2 ER/Out	ime of	3 LI DOA	4 LI Nursing I			e 6 □Other (Speniury occurred	ecify)
ion	nding ath. r: After e funer	atior	1 X Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da	y, Year) Ir	njury	28c. Injur Wor M 1 🗆	ḱ?  Yes 2 □ No			,,	
Division	or Attencater death Director:	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ot be ned 28e. Place of Inj	ury - At home, far c. <i>(Specify)</i>	m, stree	et, factory, office		28f. Location City or To			Bural Route Number,
Ö	ital or rs afte al Dir	Cer	, <u></u>	ballang, co	o. (opoony)				City of 7	0 1111, 01	idic)	
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in the Funeral Director Complet	Medical	29a. Certifier 1 💢 Certifying (Check only one)	Physician: To the best xaminer: On the basis of and manner st	f examination and	, death o d/or inve	occurred at the ti estigation, in my o	me, date and plac opinion, death occ	ce, and due to the time	ne caus e, date	e(s) and manner a and place, and du	as stated. e to the cause(s)
	Vithi Vithi Com	Ž	29b. Signature and ditterof pertitler				29c. Licens	se number		29d.	Date signed (Mon	th, Day, Year)
			11 Miles				D0875	5			8/11/0	18
1	L(5)		30. Name and a drest of person w	·			•	<b>"</b> 205			///	0
1	- 01	10	THOMAS BENSINGE 31. Date filed (Month, Day, Year)		ENWAY CI ar's Signature	£NTE	K DRIVE	#205 (	GREENBEI	л,	MD 2077	U
•	Sta Registr		AUG 1 1 2008		& Spen	Z.						

Eugenio Machado, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904 31. Date filed (Month, Day, Year) State AUG 0 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D24035

August 7, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 5,17 per fh g882 8-25-08 vt 106
State of Maryland / Department of Health and Mental Hygiene  $_{\text{Reg. No.}}2008$ Certificate of Death I. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day **Physician** Year WILLIAMS 5:23 AM OVETTA AUGUST 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 11/6/1959 5. Social Socurity Number Birthplace (State or Foreign Country)
 LIBERIA 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 212<del>-39</del>-8739 Yrs. 48 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland tital Hygiene.

Indoord other than "natural", or Items 23a or 28a-f show 10a. State 10b. County Anne Arundel 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f sho miner must be notified at MD PRINCE GEORGE LAUREL 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 20724 UNITED STATES 262 MARGANZA SOUTH Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 Specify.BLACK 1 ☐ Yes 2€ No 2 Specify: 3 Widowed 4 Divorced Exa Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) LIBRARIAN PRIVATE 4 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be n. Department of Health and Mental Himportant: If Item 27 is many Injury or other Be MOMO F. TLOWERS Jones ALLIETTE BENSON മ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES A. WILLIAMS/ HUSBAND 262 MARGANZA SOUTH., LAUREL, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State HARMONY MEM. CEMETERY 8/23/08 LANDOVER, MD. 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service License 22. Name and Address of Facility CAPITOL MORTUARY N.E. WASH., D.C. 20002 1425 MARYLAND AVE., complications that caused the death. Of only one cause on each line. 23a. Part 1. Enter the disease, shock, or heart failure. L not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final INTRACRANIAL HYPERTENSION **Physician** IDAY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CENTER RAL EDEMA DIFFUSE IDAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed physician and as the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) page 2 should be detached 2 X No the 9 I Inknown Division of Vital Records, P.O. 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ SEIZURES 1 Tes 2 No 3 Probably 4X Unknown Completed STROKE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has The 2 No 1 ☐ Yes 2 ☑ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☑ No Hospital: 1 MInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: I or Attending F s after death. i Director: After t 1 Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 24 hours Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (check only Medical one) To the within 2 29b. Signature and title of confire 29c. License number 29d. Date signed (Month, Day, Year) 1 ans D0062448 M.P ANGLIUST 06,2008 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEERAT NAVAL M.D. 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 1 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#24a perVERB G882 8/25/08 WS
State of Maryland Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 8/17/2008 Joan Cordrey Wheatley 9:03 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 101 Chambers St. Preston Caroline If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1 M 2 M 67 212-40-8494 Director 4/16/1941 Maryland Usual Residence of Decedent Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Ex. miner must be notified at 1 es 2 No Directo Maryland Caroline Preston the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 101 Chambers St. 21655 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 O 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iten important: or the traumatic event, the Medical Exemines once. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jones V. Mills Margaret Morris မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Chambers St., Preston, MD 21655 Leonard H. Wheatley / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 ☐Removal from State 8/20/2008 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Hurlock, MD ure of Funeral Service Licenses 22. Name and Address of Facility Lef Curran-Bromwell Funeral Home, P.A., 308 High St. Cambridge, MD 21613 ase or complications that caused the death.
re. List only one cause on each line. Approximate Interval Between Onset and Death Part . Enter the diseas shock, or heart failure Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death detached 9 Unknown 9 Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2**X** No Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital Other: 4 \sum Nursing Home 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 5 Residence 6 □Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending ospital ...
4 hours after dea.
-val Director: Aftr Natural 5 Pending investigation Injury 1 Tyes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours af

To the Funeral D

completely filled in 1 X - ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature 29d. Date signed (Month, Day, Year) nd title of cortifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David H. Smith, M.D., 8221 Teal Dr., Suite 302, Easton, MD 21601 31. Date filed (Month, Day, Year) Registrar's Signature 32. State

DHMH 17 Rev 1/2001

Registra

			For State Registrar	State of Marylar		partment of F <i>ertificate of</i> .			giene Reg. N	) [ ] [ ] [ ] [	27301
	Physici	an	1. Decedent's Name (First, Middle, Last					2. Date of De Month	Day	y Year	3. Time of Death
	/Medio		Harvey R. Will  4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of De	eath Tuges	4c.	County of Death	10730
أنجسه	۰			s Hospita		(Au) If Under 1 Year	Jely If Under 24 F	- In La Day (D)	Ti	rince (	serges
	Funeral Director		5. Social Security Number 6. Sec. 15. 579-54-0168	am 2□E	last birthda 59 Yrs	Months Days	Hours M	Irs. 8. Date of Bir (Month, Da			place (State or Foreign intry) NashDC
			Usual Residence of Decedent  10a. State 10b. County		ty, Town or	Location		TOULY	20,		10d. Inside City Limits
	Maryla -f sho	ţō	DC		shind						1 X Yes 2 □ No
	or 28a	Director	10e. Street and Number		211 1110	10f. Zip Code			10g. Citi	tizen of What Cou	ntry?
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136	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Evaminer must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1	.S. 1	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Ispanic Origin? an, Mexican, Pu Specify:	r (Specify Yes of No Juerto Rican, etc.)	}-	14. Race - Ameri Black, White, Specify: B1	
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Maryland 2		Be Cc	17. Father's Name (First, Middle, Last)		1 2 1 1	nting Pl		Name (First, Middle		SPO Surname)	
ylar	should be and Mental s marked o umatic ev	To E	Harry William					erine S			
Ma	ra tra		19a. Informant's Name/Relationship (T)		33	ailing Address <i>(Street</i> 43 C St.	.SE #3		er, City o	r Town, State, Zij	p Code)
re,	ss 1 and of Health Item 27 other to		Miguel Williams 20a. Method of Disposition	20b. I	Place of Dis	shington sposition (Name of rematory or other plan	<del>, DÇ Z</del>	Date	20c. Lc	ocation - City or To	own, State
Baltimore,	permit. Pages Department of I Important: If Ite any Injury or o		1 ☐ Burial 2 🛣 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	removal nom state		ale Park	Crema	/21/08 tory		verdale	
Rail	Depart Depart Import any In	!	21. Signature of Funeral Service Licens	5 12		22. Name and Addre					
			23a. Panty. Enter the disease, or complish o'k, or heart failure. List only o	ications hat caused the dear	th. Do not	3910 Sil	ver Hi	LL KO., diac or respiratory a	Su1 arrest,	tland,	MQ . 20 / 46 Approximate Interval Between
200	Physician		Immediate Cause (Final disease or condition	ne carse on each line.  Artenios	de	witic H	pert-	and we k	tean	T Dise	
	/Medical Examiner		resulting in death)	Due to (or as a consec	uence of):						
		je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a combac	(dende of):					-	
	ecuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
90,	tificate be executed g physician and as the burial-transit	al E	resulting in death) Last	Due to (or as a consec	quence of):						
98/60	tificate ig phys as the	ledical		d							
O. Box	e death certific the attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 9 ☐ Unknown	al death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	гу			23d. Date of delive Month	very Day Year
J.	requires that the een signed by the rould be detache		Part II. Other significant conditions co	ntributing to death but not res	sulting in the	e underlying cause giv	en in Part I.	23e. Did	tobacco ı	use contribute to	the cause of death?
rds	equires en sign	ed by	Dinbe	tes				10	Yes 2	□ No 3□ Pro	obably 4. Unknown
Hecords,	law as b 2 st	Completed						24a. Was	psy	prior to co	topsy findings available completion of cause of
_	an: The tiflicate h or, page	e Col	25. Was case referred to medical				OS Diana of	1 ☐ Yes		death? 1 ☐ Yes	2 ZiNo
_	ding Physician: h. After this certifica funeral director, p	To B	examiner?	Hospital: 1 ☐ Inpatient 2 €	ER/Outpa	tient 3 DOA Oth	or:	ng Home 5 ☐ Res		6 ☐ Other (Spec	eify)
_	ling Pl	ion:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Tim Injur	y Vor		28d. Describe	how injur	ry occurred	
DIVISION	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm,		lYes 2□No	28f. Location	(Street ar	nd Number or Ru	ral Route Number,
5	ital or irs afte raf Dir lled in		4   Homicide	building, etc. (Speci	· (v)			City or To	wn, State	3/	
,	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	29a. Certifier  (Check only one)  1 Certifying Phy  2 Medical Exami	sician: To the best of my kno iner: On the basis of examinating and manner stated.	owledge, dation and/o	eath occurred at the ti r investigation, in my	me, date and popinion, death o	lace, and due to the occurred at the time	e cause(s , date an	s) and manner as d place, and due	stated. to the cause(s)
5	To the within To the complete	Me	29b. Signature and title of certifier	10 -		29c. Licens			29d. Da	ate signed (Month	, Day, Year)
			1 Commoder	grate 3	20	Ho	0537	27	Au	gust 13,	, 2018
			30. Name and address of person who co	1.00		tospita	( 20,0	re Cha	كريض	? Man	ylad
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 2 5 2008	32. Registrar's Signa		ed .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 008 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Aug 19. 2008 5:00am Sr. Ware Donald C /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Allegany Cresaptown 14013 Cedarwood Dr. SW Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Davs Hours Min. 1□M 2□F Sep 14, 1938 МD Director 219-34-7293 69 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Yes 2□No Cresaptown MD Allegany Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 14013 Cedarwood Dr. SW Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. tx Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. Completed by white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Local 568 12 <u>Ironworker</u> 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any linky or other traumatic event once. Be Amber Belle Cole Ware Roy L. Ware 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21502 14013 Cedarwood Dr. Cresaptown wife Phyllis Ware 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/22/2008 MD Sunset Memorial Park Cumberland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Line 108 Virginia Avenue: Cumberland, MD 21502 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease Condition resulting in death) Physician /Medical Due to (or as a consequent e of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner certificate be executed and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical as the I attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 I Inknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions appriributing to death but not resulting in the underlying cause given in Part I. ģ 3 ☐ Probably 4 ☐ Unknown 2 No 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autoosy performe certificate 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ☐ Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a To the Funeral I 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0033280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) /0 625 KENT AVE. CUMBERLAND, MD

Registrar DHMH 17 Rev 1/2001

State

SUNIL GUPTA

AUG 25

31. Date filed (Month, Day, Year)

MID

32 Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** OI OO AM Pamelo 2008 Iowanda /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Presbury Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Min. Days 1 □ M 2 Ø F Hours 39 06 Director MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits !/ is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director MARYLAND BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3000 PRESBURY STREET 21216 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Black, White, etc. 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 Xio Specify. Completed by BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade DOMESTIC MALLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jee, Maryla. Jermit. Pages 1 and 2 should be 1 Department of Health; and Mr Important: If item 27? any Injury or r." and Mental CLEMSON PHILLIP AYE JR. MARIE MOTEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clemson Aye/Father 3000 Presbury St., Baltimore, Maryland 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 08/29/08 MARYLAND NATIONAL LAUREL, MARYLAND 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Sign whe of Funeral Service Lice Part1. Enter the disease, or conshock, or heart failure. List or plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Immediate Cause (Final Encephali **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Humm 1 mmunock Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) physician Physician/Medical the ass IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 Z No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 autonsy perform certificate 1☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

P.O. Box 68760 Division or Vital Records, filled in by the funeral Director; To the Hospital or within 24 hours af To the Funeral D

State Registrar 31. Date filed (Month, Day, Year)

29a. Certifier

29b. Signature and title of certifier

Medical

and manner stated

1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

527 Linden Aue, Suite 3EF, BAH10

BAHMORE 2120

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

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completely

Registrar

Medical

(Check only

29b. Signature and title of dertifier

this mo 29c. License number

D 41410

29d. Date signed (Month, Day, Year)

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D., JOGINDER P. MEHTA. 7601 OSLER DRIVE. TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year)

32. Registrar's Signature AUG 2 6 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** LLEN Rus. 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPICE 10 W 50N 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Year) 1**X**M 2□ F Months Davs Hours Director MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Marylan halth and Mental Hyglene.

7.27 is marked other than "natural", or items 23a or 28a-f show er traumatic event, the Medical Examinar must be neithed at 1 ☐ Yes 2 ☑No Funeral Director BALTIMORE 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code U. S. A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2X No Maryland 21215-0036 1 ☐ Yes 2 KNo Specify. Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 1 and 2 should be 1 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PARENTS 3678 Department of Heal Important: If item 2 any Injury or other once. other Baltimore, 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐ Removal from State of Funeral Service License Approximate Interval Between Onset and Death 23a. Rart I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ING COUR /Medical Due to (or as a c risequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertain Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): that the death certificate be execute sician and burial-trans Due to (or as a consequence of) 68760 Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, \$ 1 Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an aw has page 2 autopsy performed? Yes 2 certificate 1 □Yes Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2√1 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To of this 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide filled in To the Hospital of within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) completely and manner stated. 29b. Signature and title of certifier

Registrar

State

Charles ST Dayson ND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHAMBS WM 6701 NO

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 30 AM NOUST 2008 OAN /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. **Examiner** FUTURECARE hesapeake RUNDEL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/04/1926 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 PF 214-22-3608 81 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or items 23a or 28a-f show diral Examiner must be notified at 1 ☐ Yes 2 ☑No Director Anne Arundel Pasadena 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code be filed within 72 hours after death with that Hygiene. 225 Dale Road 21122 U.S.A. Funeral 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
7 Is marked other than "nature traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hutzler Brothers Cashier-Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur Erbe Elizabeth Schopp ဥ 19a. Informant's Name/Relationship (Type. Print)
Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Arthur Blanchard/in-law Arbutus Road, Pasadena, MD 21122 8426 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any Injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 08/28/08 | Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cem 22. Name and Address of Facility G.J.Gonce Funeral Home, 21. Signature of Funeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PNEUMONI disease or condition resulting in death) /Medical Due to (or as a consequence of) TIVE PULMONARY DISPASE Examiner HROM C Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, nding physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy signed by the atte I be detached for 4□Pregnant at time of death 5 Other (specify) P.0. 9□Unknown 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaced use contribute to the cause of death? Division or Vital Records, þ CHRONIC RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed RHEUMATOD 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performe this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tyes ပ To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral to 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 □Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar 29b. Signature and title

DHMH 17 Rev 1/2001

Registrar

P.O. Box 68760.

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Physician BRODNAX 05:24 M AUGUST PATRICIA 25 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.
Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Days 44 May 7, 1964 Maryland 220-92-0090 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 X No Director MD Howard Jessup 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 9996 Guilford Road 20794 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2X No 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married ò 1 ☐ Yes 2X No White Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) than Il Hygiene. Secretary Roofing 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file ment of Health and Mental Hy ant: If item 27 Is marked oth Be Curtis R. O'Donell မ Brenda L. Phebus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9996 Guilford Road, Jessup, MD Don M. Brodnax/Husband 20794 t: If item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Union Cemetery 8/29/2008 Burtonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 | 313 Talbott Avenue, Laurel, MD 23a. Part 1. Enter the disease, or complications shock, or feart failure. List only one cultimediate ause (Final Approximate Interval Between at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Onset and Death *entricular* hour **Physician** disease or condition resulting in death) /Medical Examiner Wears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Tyes Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be xaminer? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital: 1 Inpatient 1 Yes 2 □ No 2 ER/Outpatient 3 DOA ၉ Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury Time of Medical Certification: (Month, Day Year) 5 Pending investigation Injury 1 Natural 1 🗌 Yes 2 🗆 No death. 2 Accident in by the Director 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. To the Vithin 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AUGUST 25, 2008 MEDICAL DOCTOR

State

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Division of Vital Records,

31. Date filed (Month, Day, Year) AUG 2 6 2008 Registrar

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and address of person who completed cause of death (Item 23a) (Type, Print)

RES-000

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-06467 amend #20c Per FH G/26/08 The Certificate of Death 2008 27309 Catherine Teresa Brown 1- For State Reg. No 2. Date of Death Registrar Decedent's Name (First, Middle,Last) Month Day August 23, 2008 Physician/ 2235 hrs Brown Medical Examiner Teresa Catherine 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Montgomery Village 9412 Vineyard Haven Drive 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or if Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. Country) NY 01 27 68 Director Yrs 40 M 2 XF 062-62-3695 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a, State 10b. County 1 Yes 2 XNo Montgomery Village Montgomery 28a-f show MD notified at once. 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Number U.S.A. 20886 9412 Vineyard Haven Drive death with the 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Funeral 11 Marital Status White, etc. must be Armed Forces? Married 1 X Never Married Yes 2X No Specify: Black Yes 2X No specify: If Yes, Give Year Pages 1 and 2 should be filed within 72 hours after tment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", o or other traumatic event, the Medical Examiner in Divorced Widowed 16b. Kind of Business/Industry à 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Beauvoir School Completed College (1-4 or 5+) Elementary/Secondary (0-12) District 21215-0036 Teacher 8yrs+ 12th grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Be Howard R. Brown
19a. Informant's Name/Relationship (Type, Print ) ဥ 197 Heritage Point, Williamsburg, VA, e of Disposition (Name of cernetery, Date 20c. Location - City or Town, State 23188 2 Howard Brown-Father 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Itimore, crematory or other place) 1X X Burial 2 Cremation 3 Removal from State Bronx 8/30/08 NY Brong Important: injury or oth Woodlawn 4 Donation 5 Other Specify 22. Name and Address of Facility Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart permit Departn Signature of Funeral Service License Md Approximate Interval Between Onset and Physician fature. List only one cause on each line Death 'Medical Contact Gunshot Wound of Neck Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed tending physician and use as the burial - tran Physician/Medical UNPENDED AMENDED 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth the attending past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? certificate has been signed by the ector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown 2 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of autopsy death? performed? 2 1 🗸 Yes Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical funeral director, Division of Vital Be Other<sub>4</sub> Nursing Home 5 Residence 6 ✔ Other: Scene Hospital: examiner? DOA Inpatient 2 ER/Outpatient 3 1 V Yes this 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury 28b. Time of Injury 27. Manner of Death After Subject shot Aug 23, 2008 2235 hrs Certification 1 Yes 2 ✔ No thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu 1 Natural Pending 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 9412 Vineyard Haveri Drive, Montgomery Village, MD Could not be 3 Suicide determined (Specify) Single Family Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal within 2 To the 1 one) Medi and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 24, 2008 O.C.M.E. W- 1201 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 6 Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11:50 AM august **Physician** Blanchard 20 н. Flora /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Keswick Nursing Home Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 229-24<del>-</del>6956 93 03 09 VA Director Usual Residence of Decedent 10d Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Pikesville Baltimore Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural"; or items 23a or 2: any injury or other traumatic event, the Medical Examiner must be once. U.S.A. 21208 8529 Meadowsweet Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 騺 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Norfolk City Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Teacher Public School 6yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clara Sutton Edward Jefferson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8529 Meadowsweet Road, Pikesville, Md 21208 Joyce Williams-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Roosevelt Memorial 8/27/08 Chesapeake, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West Im 21215 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End-stage dementia Physician ears. /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To this 27. Mann of Death funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? After (Month, Day Year) Injury 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a To the Funeral L Hospital 1 / Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

700 W. 40 16 STREET, BALTITICRE, NO 21211 MARSRESOR 7. ISABELLE 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2008 6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Registrar

gor TO

29c. License number

29d. Date signed (Month, Day, Year)

21,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 04:40 PM AUGUST Bailey 2008 /Medical Evelyn 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL BALTIMORE Year) 28 Birthplace (State or Foreign Country) Social Security Number **Funeral** 1 ☐ M 2 💢 F Months Days Hours Min 80 212-28-2968 Director 03 03 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1√2 Yes 2 □ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō U.S.A. 21216 2933 Allendale Road Apt T or items 23a Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 | Yes 2 | No If Yes, Give Year or Dates: 1 ☐ Never Married 🎾 ☐ Married 1 ☐ Yes 🏖 ☐ No Specify: Š Specify Black 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, II \*\* IN\* office. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 6th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Woodard Hughley Stevenson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 19a. Informant's Name/Relationship (Type. Print) 2933 Allendale Road Apt T, Baltimore, Md Deborah Ann Bailey-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Parial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Pikesville, Md 8/28/09 Druid Ridge al. Sign turn of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, 21215 Baltimore, Md ert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician RESPIRATORY disease or condition resulting in death) Acute DISTRESS SYNDROME /Medical Due to (or as a consequence of) Examiner Preumonia Sequentially list conditions, if any, leading to hime diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner bee to (or se a concequence of) burial-transi and Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MYOCARDIAL INFARCTION 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? RENAL FAILURE 24a. Was an autopsy performed certificate 2 No HYPOTENSION 1 □Yes 2 No 1 ☐ Yes funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □No investigation 2 Accident the 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

The law requires that the death certificate σ. of Vital Records, or Attending after death. 24 hours a Hospital within 2

Baltimore, Maryland 21215-0036

permit.

be executed

o

State Registrar

MP MICHPE JANTON AN 31. Date filed (Month, Day, Year) AUG 2

and title of certifier

29b. Signature

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

SINAT HOSPITAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Bertha Brendle m. 08 8:40A M 20 2005 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Tate Hospice House Linthicum Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday Date of Birth (Month, Day, 1 □ M 2 F Days Months Hours 220-14-6606 Director 84 Yrs June 9 1924 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f shov Director 1 ☐ Yes 2 No Anne Arundel Glen Burnie 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 129 Louise Terrace 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married □Yes 2 Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Completed by 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental ls marked Thomas McGahan Bertha Mae Hauth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr once. Mrs. Dawn Stilley/Daughter 4607 Kramme Avenue Baltimore MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Atantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Mol357 Services 1 2nd Avenue SW Glen Burnie, MD 21061 anua 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or cart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** huesta static reast disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and the burlal-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) 1∐Yes 2⊠No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? has been signe je 2 should be d þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 2 No 1 ☐ Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOTA 120 Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cheep of death (Item 23a) (Type, Print)

State Registrar DAVID

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egistrar's Signature

Hospital &, 613, and 2,061

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** Phyllis Helene Bloodgood 20, 2008 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery Bethesda 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🔀 F 79 July 16, 1929 Massachusetts 155-22-4326 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ral", or Items 23a or 28a-f show Examiner must be notified at 1 □Yes 25 No Director Maryland | Montgomery Derwood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 16805 Bethayres Road 20855 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White þ 3 ₩ Widowed 4 Divorced "natural". Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) other than Elementary/Secondary (0-12) Nursing Supervisor Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Matthew James ပ Mable Hodnett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is rr any injury or other traum once. 3504 Marigold Drive, Monrovia, Maryland 21770 Cheryl Bloodgood Thomas/Daughter 20b. Place of Disposition (Name of Monte Of Monte Of Monte Of Crematory or other place) Crematorium, Inc. 20c. Location - City or Town, State 20a. Method of Disposition August 23, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Bethesda, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Licensee M01498 M01498 | Rockville; Maryland 20850 | Rockville; Maryland 2 Immediate Cause (Final disease or condition resulting in death) **Physician** Ischemic Colitis /Medical Due to (or as a consequence of) Examiner Peripheral Vascular Disease Sequentially list conditions, if any, loading to finine dute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Congestive Heart Failure Due to (or as a consequence of) that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ The law requires 1

Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate 1 ☐ Yes Vital 2 🗷 No Physician: Be funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred i or Attending Patter death. Division 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral Completely filled 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, în my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number (20066264) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

South Washington Street, Easton, Maryland 21601 Babaic 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 25

DHMH 17 Rev 1/200

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2008 9:50 A M **Physician** August Ethel Jones Beasley /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Wilson Health Care Center Gaithersburg Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 □ M 2**X** F Florida 91 December 16, 1916 262-20-9602 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 √ Yes 2 No Rockville Director Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or items 23a or Examiner must be n United States 20850 810 Fordham Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🛣 No Specify Specify: White þ 3 X Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Real Estate Agent permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 Is marked other t any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Allen Orem Raleigh Jones ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rockville, Maryland 20850 810 Fordham Street Mary Allen Beasley / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. Aug. 22, 2008 | Bethesda, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue Rockville, Maryland 20850 of Funeral Service Licenses dentos 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final months Physician disease or condition resulting in death) /Medical Due to (or a d consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part JI. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Certification: To Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 ☐ Yes 28d. Describe how injury occurred 27. Manual of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide

or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, been signed by the should be detached has e 2 certificate After within 24 hours after death

To the Funeral Director: A

with the Maryland

filed within 72 hours after death Hygiene.

Baltimore, Maryland 21215-0036

"natural", or

Is marked other than

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 37 Registrar's Signature

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

004115

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Marylar	Cer	tificate of l	Death	Re	<sub>9g. No.</sub> 2	008	273	115
(C	Physicia		1. Decedent's Name (First, Middle, Last)					Date of Deat     Month	Day	Year	3. Time of E	
	/Medic	al _	Patrick Micha  Aa. Facility Name (If not institution, give str		agan	4h City Town or	Location of Death	August	23,	2008 nty of Death	8:45	Α
)	Examin	er	1614 Four George		pt1A	Dunda				ltimo	re	
***	Funeral Director		5. Social Security Number 6. Sex 153 - 62 - 2558	7. Age ( <i>In yr</i> s.		If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, Mar 26,	Year)	Cour	olace (State or otry) yland	Foreign
	and		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Loc	cation				1	Od. Inside City	/ Limits
	Maryla -f sho ied at	ţo	Md. Baltime	ore	Dunda	alk					1 ☐ Yes	2 <b>∑</b> No
	th the	)irec	10e. Street and Number			10f. Zip Code		1	•	of What Cour	ntry?	
	ath wir	ral	1614 Four George		pt 1A	21222		ecify Ves or No.		S . A . Race - Americ	can Indian.	
326	should be filed within 72 hours after death with the Maryland to Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show marked other than "natural", or Items 23a or 28a-f show matic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 34☐ No If Yes, Give Year or Dates:		f Yes, specity Cubi	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	1	Black, White, ec <i>ify:</i> Whi	etc.	
Š Š	72 hou natura ilcal E		15. Decedent's Educa (Specify only highest grade	ation completed)	16a. Deced	lent's Usual Occup kind of work done	oation during most of work d)	ing	16b. Kind o	Kind of Business/Industry		
121	within ane.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Labo		a)		Cor	Construction		
2	filed in Hygie other the ent, the	Be Co	17. Father's Name (First, Middle, Last)		варс	J. CI	18. Mother's Nam	e (First, Middle,			001011	
/lan	uld be Menta irked itic ev	To B	Thomas Branagan				Edith				210	222
a	2 sho and Is m		19a. Informant's Name/Relationship (Type Patricia E. Bra:	e. <i>Print)</i> nagan/wife	19b. Mailin	ng Address (Street Four Ge	and Number or Ru	ral Route Numbe Court A	r, City or To	wn, State, Zij A Bal	timor e	e, Md
ē,	1 and Health tem 27 other tr	}	20a. Method of Disposition	20b.		sition (Name of natory or other pla		Date		on - City or T		
Ē	Pages nent of nt: If ii		1 Surial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State O	ak Lav	vn Ceme	terv8-26	5-2008	Balt	imore	,Mary]	Land
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service License	LEV-	12	201 Dune	ess of FacilityKac	e. Balt	imor	unera e, Md	1 Home . 2122	e,PA 22
h	A-		23a. Part1. Enter the disease or complice shock, or heart failure. List only one	ations that caused the dea cause on each line.	ath. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory are	rest,		Approximate Interval Bety Onset and D	veen Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	METASTAT		LUNG	CAUCER	2		-		
	Examiner			Due to (or as a conse	equence or):							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	equence of):						<u>-</u>	
	ecuter and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):							
68760,	tificate be executed g physician and as the burial-transit	alE	4		. ,							
		Aedical	IF FEMALE.						4-			- 12-03
P.O. Box	e death cert he attending ed for use a	Physician/M	in the past 12 months?	c. If yes, outcome pf preg 1□Live birth 2□Fe 4□Pregnant at time of 9□Unknown	tal death 3	⊒Ectopic pregnand ⊒ Other (specify) _	;y		23d	. Date of delive Month		/ear
<u>Ч</u>	that the	Phy	9 ☐ Unknown  Part II. Other significant conditions con	tributing to death but not re	esulting in the u	inderlying cause gi	ven in Part I.	23e. Did to	obacco use	contribute to	the cause of d	leath?
rds	quires n sign ald be	d by						1 📭	res 2□1	No 3□Pro	obably 4 □t	Jnknown
Division or Vital Records,	To the Hospital or Attending Physician: The law requires that the death cenwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Completed						24a. Was autop perfo 1 Yes	rmed?	24b. Were au prior to c death? 1 ☐ Yes	topsy findings ompletion of c	available ause of
/ita	clan: ertifica ctor, p	BeC	25. Was case referred to medical examiner?			100		ith (Check only o	ne)			
<u>^</u>	Attending Physician: r death. ector: After this certifica by the funeral director, I	P	1 Yes 2 No	ospital: 1 ☐ Inpatient 2  28a. Date of Injury	ER/Outpatie	nt 3 DOA		lome 5 Resid			cify)	
Ou	ding I h. : After funer	tion:	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)		Wo	ork? ]Yes 2∐No		,,			
Divisi	al or Attent after deat I Director d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At building, etc. (Spe		reet, factory, office		28f. Location (S City or Tou		lumber or Ru	iral Route Num	nber,
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	ician: To the best of my kner: On the basis of examinand manner stated.	nowledge, dea ination and/or i	th occurred at the nvestigation, in my	time, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) ar date and p	nd manner as lace, and due	stated. to the cause(	s)
	To the within To the comp	M	29b. Signature and title of certifier	540			se number			signed (Month		
	~		companican				16619				5, 2008	
	1		30. Name and address of person who co	mpleted cause of death (It	em 23a) (Type 40 FR	, Print)	SQUARE	DR. W.	HITE M	ARSH, K	10. 212	236
	St	ate	31. Date filed (Month, Day, Year) AUG 2 5 20	32. Registrar's Sig	mature	made						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b State of Maryland / Department of Health and Mental Hygiene Per FH G883 9/09/08 JH Certificate of Death Reg. No. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** REBA FERN BIEMILLER 6:31 P<sup>M</sup> AUG. 23. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL HOSPICE DOVE HOUSE WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/29/1919 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex Days Hours 1 □ M 2 🕱 F MARYLAND Director 89 217-26-9685 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No MD CARROLL WESTMINSTER 10e. Street and Number 10g. Citizen of What Country? 0 225 FROCK DR., APT. 334 21157 USA Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Completed by Specify: WHITE 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nany injury or other two." Pages 1 and 2 should be filed within Elementary/Secondary (0-12) College (1-4or 5+) OWNER DAY CARE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **ALEXANDER** GLADYS COOPER WALTER ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEB BIEMILLER - SON 388 HAWTHORNE, CT., WESTMINSTER, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State FINKSBURG, MD 4 Donat 5 Dotter (Specify) EVERGREEN MEM.GARDENS 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. of Faheral Service Licensee 21. Signatur 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) premono **Physician** 17075 /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physiclan: The law requires that the death certificate be executed hin 24 hours after death. Due to (or as a consequence of). physician Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 2 No 1 Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐Yes 2 ☐ No eral Director: / Investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Funeral 29a, Certifier 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) 10059943 25,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 570 mn( Melins 295 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 26 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** PM 3:10 **BARSHAY** Aug. 23 SARRA 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE JEWISH CONVALESCENT & NURSING BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day Year) 07/02/1923 Birthplace (State or Foreign Country)
 DICCT \*\* 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 NF Days Hours RUSSIA 213-35-1475 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "neturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7920 SCOTTS LEVEL ROAD 21208 RUSSIA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 XNo Specify: þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) Colfege (1-4or 5+) HOMEMAKER 12 OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be KLOPOUH UNKNOWN AARON ADELA ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a. Important: If Item 27 Is eny injury or other treu ARKADIY BARSHAY / SON 28 JONES VALLEY CIRCLE, BALTIMORE, MD 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 08/25/2008 REISTERSTOWN, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death of Alzheimer's Immediate Cause (Final disease or condition resulting in death) End Stage demention
Due to (or as a consequence of): Physician End 1 months /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner been signed by the attending physicien and should be detached for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ξ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 2 No 1 Yes After this certification funeral director, I Be 25. Was case referred to medical 26. Pface of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending s after death.

I Director: Aft
id in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire ō To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Begun. MD D0053928 08/24/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURATYA W. BELVEDERE AVENUE, BALTIMORE, MD 21215 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician 4:30 PM emons 2008 16 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** timore If Under 24 Hrs. **Funeral** Months Days Hours 1 □ M 2 🔭 016-42-2043 Usual Residence of Decedent **Director** permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event. If all Mental and Injury or other traumatic event. If all Mental and Injury or other traumatic event. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Xes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 ∐Yes No If Yes, Give Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2√No Specify þ 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) timore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be မ 19a. Informant's Name/Relationship (Type: Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name 20a. Method of Disp Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of lying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ORKRU Baltimore, ND 21 Immediate Cause (Final disease or condition resulting in death) distase **Physician** years /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or a consequence of) or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>^</u> funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □Yes 24a. Was an autopsy performed? res 2 DNo Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director. 2 Accident investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) fillec in by 4 Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person with 70

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Sigg

		1 - For Amend Item 24: Registrar	State of Marylar	19882 988 Cer	726/086 tificate of	Health and I Death	Mental Hygi Rei	ene g. No. 200	8 27319		
Physicia /Medic		1. Decedent's Name (First, Middle, Last) William T. Campbe	1				2. Date of Death Month	Day Year 15 2000	3. Time of Death		
Examin		4a. Facility Name (If not institution, give st	reet and number)	anso		or Location of Death		4c. County of Dea	ath 'MICs		
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs.	/ast birthday) 75 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month Day, NOV 10,	9. Bi	rthplace (State or Foreign ountry) Ohio		
Maryland -f show	tor	10a. State 10b. County  MD Wicomico	10c. Ci	ty, Town or Loc	cation				10d. Inside City Limits 1 ∐Yes 2∰No		
with the	al Director	10e. Street and Number 5168 Campground Ro	oad		10f. Zip Code	21822	10	g. Citizen of What C USA	ountry?		
ING Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland the Hygiene. d other than "natural", or items 23a or 28a-f show event, I've Medical Evorulner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Nover Married 2 Divorced	2. Was Decedent Ever in U Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 155—	1	Vas Decedent of f Yes, specify Cu □ Yes 2X No	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi Specify: W	te, etc.		
Z I Z I 3-U vithin 72 ho giene. r than "natur five Medical.)	Completed	15. Decedent's Educa (Specify only highest grade) Elementary/Secondary (0-12)	completed)  College (1-4or 5+)	(Give life. L	dent's Usual Occi kind of work don OO NOT use retir ute driv	e during most of wor red)		6b. Kind of Business beverag			
should be filed and Mental Hyging marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) Arthur Campbell					me (First, Middle, Malden Surname) 211a Ramage				
MICHY and 2 shou alth and N 27 is mai		19a. Informant's Name/Relationship (Typ William T. Campbel				et and Number or Au ive Salis		City or Town, State, 21804	Zip Code)		
Definitioner, INTRIVIATION Permit. Pages 1 and 2 should be Department of Health and Menti Important: If then 27 is marked any Injury or other traumatic events.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☒ Donation 5 ☐ Other (Specify)		Place of Dispos cemetery, crem	sition (Name of natory or other pl	ace)	Date 2	0c. Location - City o	r Town, State		
Dall permit. Departi Importi any Inji		21. Sign to Funeral Service Licen.	de Directo	4		ress of Facility Comy Board , MD 2120		Baltimore	Street		
Physician /Medical Examiner		23a. Patt 1. Enter the disease, or complic shock, or heart failure. List only one Immediate cause (Final disease or condition resulting in death)	ations that caused the deat cause on each line.  MULTI OF  Due to (or as a consect  SEPS (S	Usence of):			or respiratory arre	st,	Approximate Interval Between Onset and Death		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner										
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To t with To t	Σ	29b. Signature and title of certifier  What L. L.	2gburn	as.	29c. Licer	3 45 9 3	29	d. Date signed (Mor	nth, Day, Year)		
12			burn 15	0 E.	,	st sa	lusbury.	MO 21.	801		
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George Wayne		State of Maryland / Department of Heal  1-For State Certificate of Deat  Registrar  Certificate of Deat			. No. 200	8 2732
Physici	an/	Decedent's Name (First, Middle,Last)	2	2. Date of Death Month	Day Year	3. Time of Death 1939 hrs
Medical Exami	ner		Town, or Location of Death	August 20,	2008 4c. County of Death	
		Howard County General Hospital Colur			Howard	
Funeral			er 1 Year If Under 24Hrs.	8. Date of Birth		hplace (State or
Director		136-44-2107 1XXM 2 F 55 Yrs. Month	ns Days Hours Min.	Aug.22	,1952 Foreig	ntry) NJ
Α.		Usual Residence of Decedent				10d. Inside City Limits
Maryland 28a-f show any d at once.		10a. State				1 Yes 2 No
ryland a-f sh t once	훵	10e. Street and Number 10f. Zip	Code	1100	. Citizen of What Cour	
he Ma or 28	Director	8526 Clarkson Drive 207		l T	USA	
1215-0036 Id be filed within 72 hours after death with the Maryland fental Hygiene. narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must he notified at once.			ent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - Americ	can Indian, Black,
death or iter	Funeral	1 Never Married 2 XXMarried Armed Forces? If Yes, specifically Yes 2XX No	fy Cuban, Mexican, Puerto R	(ican, etc.)	White, etc.	
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	o Be		Myrtle  S (Street and Number or Ru	ral Pouta Numb	Fiske	Zin Codo)
O de D is if			kson Drive, I		-	, zip code)
ore, MD ss I and 2 sho of Health and If item 27 is her traumati		20a. Method of Disposition  20b. Place of Disposition (Nar  20b. Place of Disposition (Nar  20cematory or other place			20c. Location - City or	Town, State
MOF Pages ent of int: If		1 X Burial 2 Cremation 3 Removal from State crematory or other place 4 Donation 5 Other Specify: Mt.Zion UMC C		g. 25, 2008	Highland,	MD
Baltimore, permit. Pages I a Department of He Important: If ite injury or other tr		21. Signature of Funeral Service Licensee 22. Name and	Address of Facility Dona	aldson E	Funeral Hom	
	2	Trensile M01053 B13 Tal	bott Ave., La	aurel, N	4D 20707	
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xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive Atherosclerotic Cardiovascu	ular Disease			Death
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git q	хаш	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
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30, te be e sysicial	ledical	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	,
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To th within To th	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	c. License number	the time, date a		
	-	154 1 MS	O.C.M.E.		29d. Date signed (Mo. August 22, 2008)	
フゴ		30. Name and address of person who completed cause of death (Item 23a)			J,00	
10			Street, Baltimore, MD	21201		
		31. Date filed (Month, Day, Year)  32. Registrar's Signature		_	•	
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DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year 2/2/2/8 Donald Cougle 218:45AV /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Center Baltimore owson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days 214-40-1203 APR 30, 66 Director 1942 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examination must be notified at 1 Yes 2 No Funeral Director MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 214 Robwood Road 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Completed by Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Construction permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Cougle Dorothy Bosley ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Bosley/Cousin 3809 Sweet Air Rd Phoenix, MD 21131 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metro Crematory, Inc 8/23/08 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Cremation Society of Maryland, 299 Frederick Rd Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ISCHEMIC CARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) pplial or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by METASTATIC COLON CANCER 1 🗌 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 000 1 ☐ Yes 2 No 1 ∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1∐Yes 2XNo 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ehla m.o ,2008 22 h D41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. D. OSLER DRIVE TOWSON. MARYLAND 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 2 6 2008

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death CARSON Day **Physician** MICHAEL AUGUST 20 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Funeral Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f sho Examiner must be notifled at BALTIMORE 1 ☐ Yes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip-Code Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin?
If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 1 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: BLACK <u>م</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Public 17. Father's Name (First, Middle, Last) Be Mental marked ည 19a. Informant's Name/Relationship (Type. Print) Balto, md. 21207 Health tem 27 i or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h
Important: If ite
any injury or ot
once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BOOD Woodlawn, Md. 21. Signature o Funeral Service License Y D. CROMBETTE 7/s EdMONDSON Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Upper jastio intestinal
Due o (or as a co Jequence of): **Physician** 4 days disease or condition resulting in death) /Medical **Examiner** Gastro-esophositis Sequentially list conditions, Examiner n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physiciar Physician/Medical as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Tectopic pregnancy Month Year Day 4 Pregnant at time of death 2 No 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

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filled in by the funeral director, page 2 should be detached for After this or Attending death. Director:

To the Hospital within 24 hours a To the Funeral E

2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 1 🗆 Yes 2 No Hospital: 1 Department 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Patural 2 Accident 5 Pending investigation Injury 1 🗌 Yes 2 No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 29a. Certifier 1 Partifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

185-000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAJA ABBULNOUM

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year) AUGUST, 20, 2008

State Registrar

31. Date filed (Mor Year)

29b. Signature and title of certifier

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician )OROTHY COOPERHALL Q 20 AM 2008 AUGUST /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HUSPITAL RANDAUSTOUN NORTHWEST BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 11-13-153 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 TA **Funeral** 1□M 2√F 213-32-4218 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or 20 Kitt Ridge Court 211.33 USA ral", or items 23a Examiner must b Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 SpeciAfrican-American 1 ☐ Yes 2 No Completed by 3 Widowed 4 ☐ Divorced "natural" er than "natur, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Investigator Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward G. Cooper Annie Lee Johnson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen C. Brown/ Sister 9705 Fustice Road, Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of I Important: If ite any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Garrison Forest Veterans 8-27-08 Owings Mills, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wilie Funeral Home P.A. of Balto. Co. Signature of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical (or as a consequence of): Examiner Breust Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-trans Due to (or as a consequence of) Physician/Medical use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? the funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 10 1 Impatient ٩ 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician:

DHMH 17 Rev 1/2001

Registra

29a. Certifier

(Check only one)

RAVITE

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KHWKHM

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Medical

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5401

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

63430

COURT RO

29d. Date signed (Month, Day, Year)

21133

RANDALLSTOWN

			1 - For Amend Items Registrar amend #19a	1,23a per	yland / Depa dr. , , , , , , , , , , , , , , , , , , ,	rtment of F 08/26/08 10/16/21/20	ieaith and Death	wentai nyg	eg. No 201	08	27324
			Decedent's Name (First, Middle, Last		2 0/20/-00			2. Date of Deat Month		Year	3. Time of Death
Н	Physicia /Medic		Rev. Arthur	Linwo	od Cor	bin, Sr.			20, 20g		1:14 A M
and Service	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Dea	th	4c. County	of Death	
2			14200 W. Phoenix			Phoe	nix If Under 24 Hrs	P Date of Birth	Balt:		elace (State or Foreign
	Funeral		5. Social Security Number 6. S	ex 7.Age ( ☑M 2☐F	(In yrs. last birthday) Yrs.	Months Days	Hours Min	. (Month, Day,	Year)	Cour	ntry)
	Director		216-22-4044 Usual Residence of Decedent		79			March 22	1929	Mary	land
	ylanc how	,	10a. State 10b. County	1	Oc. City, Town or Lo-	cation				1	0d. Inside City Limits
	e Mar	Director	Maryland Baltimo	re	Phoe						1 ☐ Yes 2 🌠 No
	or 2	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	/hat Cour	ntry?
	s 23a	eral	14200 W. Phoenix	Avenue 12. Was Decedent Eve	orin IIS 12 1	2113		Specify Ves or No-		SA Americ	can Indian,
10	ter de	Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☒ Married</li></ul>	Armed Forces?  1 □ Yes 2 🏋 No			an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		k, White,	
93	ursal al", or	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 📉 No	Specify:		Specify	Whit	e
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wther than "natural", or items 23a or 28a-f show ent, the Medical Examinat must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deced	dent's Usual Occup kind of work done OO NOT use retired	nation during most of we	orking	16b. Kind of Bu	siness/In	dustry
121	/ithin ine. han "	шp	Elementary/Secondary (0-12)	College (1-4or 5+)					D	. 1 C.	
5	iled w Hygie ther t		17. Father's Name (First, Middle, Last)	n/a	<u>M</u> a	il Carri		ame (First, Middle, I			ervice
and	d be f ental ced o	o Be	George Mowell	Corb:	in		Margai		llian		eeler
ĭ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time Z? is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examinational be notified at once.	George Mowell Corbin Margaret Lillian  19a, Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town									
Š			Darce J. Corbin/		1420	00 W. Pho	enix Ave	enue, Phoe	enix, M	D 21	1131
altimore, Maryland	es 1 a of He item		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Dame State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place	ce)	Date	20c. Location -	City or To	own, State
<u>Ĕ</u>	Page ment ant: It ury o		1 △ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Conation 5 ☐ Other (Specific		Falls Rd.	U.M.C.	Cem. 3/	/23/08	Phoenix	c MI	
Balt	ermit. Separt mport iny inj		21. Sona to of uner Sarlice Con			Name and Address		ome of Dul	lanev Va	111ev	Inc
	40 Z 40 C		Bryan W Cla					ome of Dul Timonium		1093	Approximate
ı	÷		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		or the mode of dy	ng, ouer as suru	ao or roophatory arr	551,		Interval Between Onset and Death
Mark St.	Physician /Medical		disease or condition resulting in death)	a. Sent	consequence of):	AILU	<b>LO</b>			-	SHIMON &
1	Examiner		200	Periphe	eral Arter	al Disea	se				
		ner	Sequentially list conditions, if any, beauting to immediate cause. Enter Underlying Cause (Disease or injury	•	consequence ofly:						
	cuted nd ransit	Examiner	that initiated events	Diabete							
ő	oe execian a	E	resulting in death) Last	Due to (or as a	consequence of):						
68760,	ficate be executed g physician and s the burial-transit	edical		d		***					
_	eath certifi aftending I for use as	/Me	IF FEMALE:	23c. If yes, outcome of	pregnancy				23d. Dat	te of deliv	erv
Box	death after d for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death 3	Ectopic pregnand Other (specify) _	СУ			nth	Day Year
P.0.	w requires that the dispension of the stoom of the should be detached	hysi	9 Unknown	9 Unknown							
	s that gned	by P	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use cont		he cause of death?
ğ	equire een sli	ed						- 1 □ Y	es 2□No	3☐ Pro	bably 4 ☐ Unknown
ပ္ပ	2 2 2	Completed						24a. Was a autops	sv l i	prior to co	opsy findings available ompletion of cause of
<u>=</u>	: The cate h	Con						perform 1 □ Yes		death? 1 □Yes	2 □No
⋛	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	10F:	eath (Check only or		<del></del>	
<b>ŏ</b>	Phys rthis ral dil	 10	1 ☐ Yes 2 📉 No  27. Manner of Death	1 ☐ Inpatient	t 2 ER/Outpatier	f 28c. Iniu	rv at	Home 5 N Resid			f(y)
ou	ding F th. : After : funera	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day,	Year) Injury	Wor	rkí? ]Yes 2 ☐No				
Division of Vital Records,	Atter er dea ector by the	ifica	3 Suicide 6 Could not b	28e. Place of Injury building, etc.	y - At home, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Numb	er or Rur	al Route Number,
ā	tal or rs afte al Dir led in	Certification:		<u></u>							
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	29a. Certifier  (Check only one)  1X Certifying Pt  Medical Example:	nysician: To the best of miner: On the basis of e and manner state	examination and/or in	h occurred at the to vestigation, in my	ime, date and pla opinion, death oc	ace, and due to the o curred at the time, o	cause(s) and made date and place,	anner as and due 1	stated. to the cause(s)
	o the ithin of the omple	Mec	29b. Signature and title of certifier	and manner state	<del></del>	29c. Licen:	se number	2	29d. Date signe	d (Month,	Day, Year)
	F > F 0		► (//// ~		_	()4	UCI 1	6	212	010	8
			30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type,	Print)	TJC		3 (00	- , 0	7
			Jeffrey Alexar			Pierre D	r., sui	te 101, To	owson,	MD 2	21204
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 2 6	32. Registrar	's Signature	book .					
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Physic	cian
/Med	ica
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Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Registrar

	1 - State Registrar	Certi	ficate of E	Death	Reg. No. 2008 27325				
ian	1. Decedent's Name (First, Middle, Last)				eath Day	Year	3. Time of Death		
ical	Zenovia I. Courpas					t 23,	2008	4:15 A. M	
ner	4a. Facility Name (If not institution, give street and number) 78 N. Ritters Lane	4	Owings		4c. County of Death  Baltimore				
Г	5. Social Security Number 6. Sex 7. Age (In yrs. las		If Under 1 Year	If Under 24	Hrs. 8. Date of E	Birth	9. Birth	place (State or Foreign	
	217-82-3398 1□M 2 <b>C</b> XF 88	Yrs.	Months Days	Hours N	July	<sup>Day, Year)</sup> 20, 19		ntry) EECE	
	Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Locat	tion					10d. Inside City Limits	
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rect	10e. Street and Number	TCINOL	10f. Zip Code	n of What Cou	ntrv?				
Ö	4443 La Plata Avenue		212	211		US		,	
nera	11. Marital Status 12. Was Decedent Ever in U.S.	13. Wa			? (Specify Yes or I uerto Rican, etc.)	No- 14	. Race - Ameri		
Fu	Armed Forces?  Armed Forces?  Armed Forces?  Armed Forces?  Armed Forces?  Armed Forces?  Tyes 2 Envo		es, specily Cubar ∃Yes 2MiNo	Specify:	uerio Rican, etc.)		Black, White, pecify: Wh	eic. nite	
Q P	3 ☑ Widowed 4 ☐ Divorced Year or Dates:								
Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	(Give kir	nt's Usual Occupa nd of work done d NOT use retired)	urina most of	working	16b. Kind	of Business/Ir	idustry	
E O	Elementary/Secondary (0-12) College (1-4or 5+)		lomemaker				Own Ho	me	
BeC	17. Father's Name (First, Middle, Last)			18. Mother's	Name (First, Mida	le, Maiden Su	urname)		
10 E	John Fergadis			Ka	liopi				
					r Rural Route Nur				
	Kaliopi Provencher Daughter					<del></del>		and 21117	
	20a. Method of Disposition  1XI Burial 2 Cremation 3 Removal from State  20b. Place Cerr	ce of Dispositi netery, cremai Demet r	ion <i>(Nam</i> e of tory or other place <b>OIS</b>	9 8/	<sup>28/2008</sup>		ation - City or T Ley, Mar		
	4 Donatien 5 Dotner (Specify)			i	•				
	21. Signature of Funeral Service Licensee	Bu	rgee-Hen	iss-Sei	tz Funer Baltimo	al Hom	e, Inc.	. 21211	
	23a. Part I. Enter the disease, or complications that caused the death. shock or heart failure. List only one cause on each line.						Lyland	Approximate	
	I							Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death)  a.   Metastanc  Due to (or as a consequent of the conse		COMIN'S	Carre	UL OT I	ME INO	wn	6 years	
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iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	nce of):							
xam	that initiated events c	nce off.							
alE	530 10 (01 25 2 501 50 45 5	100 017.							
Medical Examiner	d								
		:y			23d. Date of delivery				
sicia	in the past 12 months?    1   Live birth 2   Fetal d	eath 3⊟E	Ectopic pregnancy Other <i>(specify)</i>		Month Day Year				
Completed by Physician	9 Unknown				T				
2	Part II. Other significant conditions contributing to death but not resulti	ng in the unde	erlying cause give	en in Part I.		_	_	the cause of death?	
eted					_				
a					24a. W	as an topsy rformed?	24b. Were aut prior to c death?	opsy findings available ompletion of cause of	
ပိ	25. Was case referred to medical				1 □Ye:	2 No		2 <b>X</b> No	
o Be	examiner?	R/Outpatient	3 DOA Othe		Death (Check onling Home 5 Re		Other /Snor	661 Daniel Inglie Lang	
<u>آ</u>	27. Manner of Death  1. Natural 5 Pending (Month, Day, Year)	8b. Time of Injury	28c. Injury Work	/ at		e how injury		DANAMES & NOT	
atio	1.★Natural 5 Pending (Month, Day, Year) 2 Accident investigation	Пјагу		r Yes 2 □ No					
tific	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stree	t, factory, office		28f. Location City or	(Street and Town, State)	Number or Ru	ral Route Number,	
Cer									
Medical Certification: To	29a. Certifier (Check only one) (Check one) (Check only o								
Me	29b. Signature and title of certifier		29c. License	number		29d. Date	signed (Month	n, Day, Year)	
	Rosalyn Junjenson		DE	020	3	Augu	st 25	, 2008	
	30. Name and address of person who completed cause of death (Item 2							21231	
	Rosalyn Juergens, and 1650 Orleans	Stree	t Johns	Hopki	ns CRBI	- 693	Baltimo	ve, Maryland	
tate trar	31. Date filed (Month, Day Jear)  22. Registrar's Signatur	Lead	* jg					•	
urali	AUG 2 6 2008 June 15	157 7348							

e Frank Charv	1-	State of Maryland / Department of For State Certificate of General Certificate of Certificate of Certificate of Certificate of Certificate of Certificate of Certificate		R	teg. No. 2008	2732				
Physicianalical Examine		Decedent's Name (First, Middle,Last) BLAKE FRANK CHARVAT		2. Date of Dea Month August 2		e of Death 05 hrs				
	4	la. Facility Name (if not institution, give street and number)  41  218 North Charles Street	b. City, Town, or Location of Baltimore		4c. County of Death					
Funeral Director	Ę	5. Social Security Number 6. Sex $_{1} \underbrace{\times}_{M} _{2} F$ 7. Age (In yrs. last birthday) $_{2} F$ $_{26}$ $_{26}$ $_{26}$	If Under 1 Year If Under Months Days Hours		rth (MM/DD/YYYY) 9. Birthplace Country)	(State or Foreign				
any						nside City Limits				
Maryland 28a-f show 1 at once.		MD N/A BALTIM	IORE		1 X	Yes 2 No				
the Maryland a or 28a-f sh tifted at onc	Dile	10e. Street and Number 218 N. CHARLES STREET, #1906	21201		USA					
JUGGO within 72 hours after death with the Maryland giene. her than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once Medical Examiner must be notified at once	Jerai	1 X Never Married 2 Married Armed Forces? If Ye	Decedent of Hispanic Origins, specify Cuban, Mexican,		0- 14. Race - American Inc White, etc.	dian, Black,				
ral", or niner mu		3 Widowed 4 Divorced If Yes, Give Year 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Yes 2 X No specify:	X IST	Specify: WHIT					
2 hours "natural Exam			's Usual Occupation (Give kest of working life, DO NOT u		16b. Kind of Business/Industr	у				
Mental Hygiene. marked other than "natu c event, the Medical Exa-	d L		STATISTICIAN Lis Mother's	s Name (First, Middle,	RESEARCH SC	IENCE				
uld be filed Mental Hyg marked of c event, the	g n	17. Father's Name (First, Middle, Last)  JAMES CHARVAT	RIC	CKIE	SLATER	-115/2				
d 2 should th and Me n 27 is ma numatic ex	2		Address (Street and Numl CROSSING VAL)		imber, City or Town, State, Zip C ATLANTA, GA 30.					
permit. Pages 1 and 2 shou Department of Health and N Important: If item 27 is n Injury or other traumatic		20a. Method of Disposition  20b. Place of Disposition  20b. Place of Disposition crematory or oth ARI TNGTON	tion (Name of cemetery, er place)	Date 8/25/2008	20c. Location - City or Town,	State				
rmit P epartme nportan jury or		111/1 1/1/1	ame and Address of Facility	SOL LEVI	NSON & BROS.,					
hysician	+	23a. Part I. Enter the disease, or complications that caused the death. Do not enter th	OO REISTERST( e mode of dying, such as ca	OWN ROAD	PIKESVILLE, MD.	21208 proximate Interval				
/Medical xaminer		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			Бе	tween Onset and Death				
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Control Control of the Control of th	Cran/	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown  23d. Date of delivery Month Day Year								
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Later of the function of the f	Completed to			24a. Wa						
ysician: The his certificate director, page		25. Was case referred to medical	26.Place of Death		2 No 1 Yes	2 No				
hysicia r this ce al direct	o Be	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient		Nursing Home 5	Residence 6 Other: Scer	ne				
ath r: After the funeral		27. Manner of Death  1 Natural 5 Pending FOUND: 28a. Date of Injury (Month, Day, Year) FOUND: Accident Investigation Aug 21, 2008 2002 hrs	njury 28c. Injury at Work	Subject jui	e how injury occurred mped from window					
pital or Attend ours after death eral Director: filled in by the	Certification:	2 Accident Investigation 3 ✓ Suicide 6 Could not be determined (Specify) Multi-Family Apt.	et, factory, office building, et	or Town,	(Street and Number or Rural Ro State) harles Street , Baltimore , M					
To the Hosp within 24 ho To the Fune completely f	न्न	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur one) 2 Medical Examiner:On the basis of examination and/or investigat and manner stated.	ion, in my opinion, death oc	ce, and due to the ca	te and place, and due to the cau					
	Σ	29b. Signature and title of certifier  Carr de Hallor	29c. License number O.C.M.E.		29d. Date signed (Month, D August 22, 2008	ay, Year)				
10	Ī	30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn S	Street, Baltimore, MD	21201						
Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature				-				
Registra	ar	AUG 2 6 2008   Been & Sp	the -							

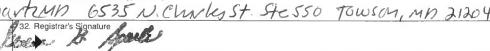
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 6:23 Рм Donald Francis Collins AUGUST 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER
Orial Security Number | 6. Sex | 7. Age (In yrs. last birthday) TOWSON BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 M M 2 □ F 88 Director 219-28-1777 11-23-1919 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be netited at 1 ☐ Yes 2 ☑ No Director MD Baltimore Lutherville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1804 Pot Spring Road U.S.A. 21093 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 1942–1945
Year or Dates. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Finance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James F. Collins ည Edith May Killmond 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Muriel Collins / Wife 1804 Pot Spring Rd., Lutherville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 08-25-2008 | Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature granneral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEVERE SERSIS WITH SEPTIC SHOCK Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner seudomembmous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed Exami attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) ed by the a P.O. 9 Unknown as been signed by the 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Tyes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of cate has by page 2 s autopsy performed? Yes 2. No certificate i death? 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊅No 1 Hnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To funeral To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 □Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registra

31. Date filed (Month, Day, Year) AUG 2 6 2008

29b. Signature and title of certifier



30. Name and address of person who completed cause of coath (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 3008 140 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** GALTIMORE 01 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) Age (In yrs. last birthday **Funeral** Months Days 1 M 2 □ F de sus Usual Residence of Decedent Director show 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Nadical Examinar must be notlified at 1 ☐ Yes 2 No Director CIERY/ AND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 91926 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced WHI Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 25/ER SYRE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2123 19a. Informant's Name/Relationship (Type. Print) Arit. Ave 157 27 2008 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location City or Town, State 20a. Method of Disposition permit. Pages 1
Department of F
Important: If ite
any Injury or ot Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funetal Service Licensee 22. Name and Address of Facility ESCOTERED BORD ( Not 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): nis certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) □Yes 2 □No Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death that not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🎉 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 25 No Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of After this completely filled in by the funeral 27. Manner of Death 1 D Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 555 ( lowscutown

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

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Year

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August

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AVIS

Registrar's Signature

			1 - For State Registrer		epartment of Health and Certificate of Death	-	ene 008	27329	
	Physici		1. Decedent's Name: (First, Middle, Last)	NN		2. Date of Death Month	Day 2008	3. Time of Death 2,49 f M	
	/Medio Examin		4a. Facility Name (If not institution, give stre		4b. City, Town, or Location of Deat	1	4c. County of Death		
			COUNTRY GALDEN		HIGHLAND	MD.	Howard		
ı	Funeral Director		5. Social Security Number 6. Sex 1 Number 16/- 34-6462	7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	(Month, Day, Y	eer) 9. Birthpl Count 1907 Thro	ace (State or Foreign try)	
			Usual Residence of Decedent	7		IMARCIA II	,		
	show	'n	MD, Howard	10c. City, Town			10	0d. Inside City Limits  1 ✓ Yes 2 ☐ No	
	the M	Director	10a Street and Number		10f. Zip Code	100	. Citizen of What Count		
	d 2 should be filed within 72 hours after death with the Marylar hard Mental Hygiene.  27 Is marked other than "naturel", or Items 23a or 28e-f show treumatic event, Ite Marylcal Examinar must be notified at	ai Di	12752 SCAGGS	VILLE ROAD	20777		USA		
	tems ?	Funerai	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, e		
36	within 72 hours after death with the Maryland ene. than "naturel", or items 23s or 28e-f show to Medical Ezaminar must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1  Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 No Specify:		Specify: WH	ITE	
21215-0036	12 hounature		15. Decedent's Educat	ion 16a. D	Decedent's Usual Occupation Give kind of work done during most of work	ting 16	b. Kind of Business/Ind	lustry	
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d 2	filled v Hygiel other ti		17. Father's Name (First, Middle, Last)	4yrs. 1	TEACHER  18. Mother's Nar	ne (First, Middle, Ma	SYST	Em	
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Maryland	2 shou and M Is mar eumati		19a. Informant's Name/Relationship (Type)	Print) 19b. f	Mailing Address (Street and Number or Ru	ral Route Number, C	City or Town, State, Zip		
	is 1 and of Health item 27 other tr		JOSEPH DUI  20a. Method of Disposition		507 MCCAHILL L		C. Location - City or Tox		
Baltimore,	Pages nent of H ant: If ite ary or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	cemetery,	crematory or other place)  SBURG Chom. Aug				
affi	그는 끝들 .		21. Signature/of Funeral Service Licensee	SITTIAL	22. Name and Address of Facility	ARYLAR	Ollins FUR	1. Itome	
ä	Depa Impo any i		> Sung a. Ro	lli	110 WGT SOUTH ST	FLEDERI	cn mo. 21	701	
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	ions that caused the death. Do no cause on each line.	t enter the mode of dying, such as cardiac	or respiratory arrest	t.	Approximate Interval Between Onset and Death	
,	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)		eimer				
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9	tificate ng phy as the	Medic							
Вох	death certific e attending p od for use as	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnancy 1□Live birth 2□Fetal death	3 Ectopic pregnancy		23d. Date of deliver	ry Day Year	
P.O.	that the de: ed by the a detached f	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)			100.	
	requires that the neen signed by th hould be detache	Completed by Physician/Med	Part II. Other significant conditions contrib	outing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	e cause of death?	
rds	w requires that s been signed I should be det	ed b	SACRAL	Decubitus	· ulcer	1 ☐ Yes	2.☑No 3 ☐ Proba	ably 4 Unknown	
ecc	S C	npiet	Heel De	cubitus u	leec	24a. Was an autopsy	prior to con	sy findings available appletion of cause of	
E E						performe	d? death? 1 ☐ Yes	312No	
Division of Vital Records,	Physician: r this certific ral director.	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	pital: 1 ☐ Inpatient 2 ☐ ER/Outp	Othor	th (Check only one)	se 6 □Other (Specify		
ا م	ig Phy ter this neral d	n; To	27. Manner of Death	28a. Date of Injury 28b. Tir	ation 30 DOA 40 Notising in	28d. Describe how			
Sior	Attending ir death. ector: After by the fune	Certification;	2 ☐ Accident investigation	(maning Day 1 Sary	M 1 Yes 2 No				
See Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural City or Town, State)  28f. Location (Street and Number or Rural City or Town, State)									
1	To the Hospital or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Physic	en: To the best of my knowledge,	death occurred at the time, date and place	, and due to the caus	se(s) and manner as sta	ated.	
	the Hc iin 24 I the Fu ipletely	ledicai	(Check only 2 Medicel Exeminer	On the basis of examination and/ and manner stated.	or investigation, in my opinion, death occu	rred at the time, date	and place, and due to	the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier		29c. License number	290	. Date signed (Month, L	Day, Year)	
	17	-	my de	letted course of death fire a co. 1	0053235	3	119/08		
1	4		30. Name and address of person who comp	3635 BAUTIN	ORE AVE LAURE	L MD. Z	20707		
	Sta		31. Date filed (Month, Pay, Year)	32. Registrate Signature					
	Registr	ar	HUU N O LOOP						

Decedent's Name (First, Middle, Last)  Physician  The Physician Communication of the Physician of the Physician Communication of the Physician of t				0.0-4(0-		
Privsteian				2. Date of De Month	eath Day Year	3. Time of Death
/Medical HAROLD WAYNE ELLER				August	23 2008	3:33 pM
Examiner 4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location of De	eath	4c. County of Dea	ath
19 ABERDEEN AVENUE 5. Social Security Number 6. Sex 7. Ac	o /la ura la at him	ABER		rs   e Date of Bir		ORD CO
Funeral Director  213-36-8608  Usual Residence of Decedent	e (In yrs. last birt	Yrs. Months Days		Irs. 8. Date of Bir (Month, Date of AUG.	y, Year)	Country)  IORTH CAROLINA
0	10c. City, Town	or Location				10d. Inside City Limits
MARYLAND HARFORD CO		ABERDEEN				1 ∐Yes 2 <b>X</b> ∑No
10e. Street and Number		10f. Zip Code			10g. Citizen of What C	country?
MARYLAND HARFORD CO    Maryland   Harford   Ha		21	001		U.S.A.	
11. Marital Status 12. Was Decedent Armed Forces?		13. Was Decedent of If Yes, specify Cu	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No lerto Rican, etc.)	14. Race - Am Black, Wh	
Solve Sear or Dates:	No	1 □ Yes 2 🕱 No	Specify:		Specify WH I	TE
15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occu (Give kind of work done	during most of v	working	16b. Kind of Busines:	s/Industry
pool of the state	5+)	`life. DO NOT use retir N/A	ea)		N/A	
To be a first first, Middle, Last)		N/A	18. Mother's N	Name (First, Middle	, Maiden Surname)	
The sponding of the sponding o			NAN	NA ELLER		
19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Address (Stree			er, City or Town, State,	Zip Code)
Karen L. Eller/Wife		L9 Aberdeen	Ave., A	Aberdeen,	Md., 2100]	
20a. Method of Disposition  20a. Method of Disposition  1 Burial 202 Cremation 3 Removal from State	20b. Place of cemeter	Disposition (Name of y, crematory or other pla	ace)	Date	20c. Location - City o	r Town, State
4 Dopation 5 Other (Specify)	METRO	CREMATORY	08/	/26/08	BALTIMORE,	MARYLAND
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23a. Part 1. Enter the disease, or complications that caused	the death. Do n				EN <u>MARYLAN</u> arrest,	Approximate Interval Between
shock, or heart failure. List only one cause on each li Immediate Cause (Final disease or condition	ne. Nie U	chemic,	honato	Linear	2.	Onset and Death
/Medical resulting in death) a. Due to (or as	a consequence of		Caron C	3-07-00-2		June
Examiner  Sequentially list conditions  b						
	a consequence c	rije.				
that initiated events  resulting in death) Last  C	a consequence o	of):				
causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as	·	•				
Medical Medical						
23c. If yes, outcome	2 Fetal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)	cy		23d. Date of d Month	elivery Day Year
Part II. Other significant conditions contributing to death b	ut not resulting in	the underlying cause g	ven in Part I.	23e. Did	tobacco use contribute	to the cause of death?
spending spe	tense	in obst	rective	_ 1 🗆	Yes 2□No 3□	Probably 4 Unknown
Physical Becords.  The Becords of Cital Becords.  The Becords of Cital Bec				24a. Was		autopsy findings available o completion of cause of
Com				— auto perfo 1 □ Yes	ormed2 death?	
A Lit and the second se			26. Place of I	Death (Check only	-	
1 Yes 2 No Hospital: 1 Inpatie		ipalient 3 DOA		g Home 5 Res	idence 6 □ Other (Sp	pecify)
To use the first of the first o	ry 28b. T y, Year) Ir	ime of 28c. Injury Wo	ıryat rk? ∐Yes 2∐No	28d. Describe	how injury occurred	
To the design of	ury - At home, far c. (Specify)	m, street, factory, office		28f. Location ( City or To	Street and Number or I wn, State)	Rural Route Number,
OIXIO  The first of the Hospital of the Homicide of the Homici	f examination an	, death occurred at the d/or investigation, in my	time, date and pl opinion, death o	ace, and due to the ccurred at the time	e cause(s) and manner , date and place, and di	as stated. ue to the cause(s)
29b. Signature and title of certifier		29c. Licen	se number		29d. Date signed (Mor	
a many lily	e www	1)2	7907		August &	25,2008
30. Name and address of person who completed cause of d	eath (Item 23a) (	Type, Print) Les St. Br	to and	21704	•	
State Registrar AUG 2 6 2008	ar's Signature	boule				

08-06233

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 27331

TICK EISETN	1- For State Certificate of Death Registrar  2. Date of Death Registrar  3. Time of Death Registrar	Donth						
Physician/	1. Decedent's Name (First, Middle,Last)  Month Day Year 1520 h							
al Examine	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death							
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State of Birth(MM/DD/YYY) 9. Birthplace (State of Birth(MM/DD/Y	te or						
Director	030-52-6467   1x M 2 F   39 Yrs.   June 21, 1969   Country)Ham	pshire						
* any	10a. State 10b. County 10c. City, Yown of Education	City Limits						
Aaryland 28a-f show i at once.	MD Prince George's Laurel    10e. Street and Number   10f. Zip Code   10g. Citizen of What Country?							
ith the Mary 23a or 28a notified at		Disast						
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5-0036 led within 72 hours a Hygiene. other than "natura th Medic   Exami	15. Decedent's Education (Specify only Highest grade completed)   16. Decedent's Education (Specify only Highest grade completed)							
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medical	10th Ø Construction Worker Construction  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	-						
215 be file ntal Hy rked o	Rodger Allen Elseth Jean Marie McAllister							
Should and Me 7 is maistic ex	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  230 Patuxent Road, Laurel, MD 20707							
and 2 sho and 2 sho Health and item 27 is traumati	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	е						
MOF	1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: West Arundel Crematory 8/21/2008 Odenton, MD							
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, th. Med	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, F	P.A.						
Physician	23a Part Share had lease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximations that caused the death.	mate Interva						
/Medical	followed ist only one cause on each line	n Onset and Death						
£xaminer	or condition resulting in death)  Due to (or as a consequence of):							
	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):							
	cause. Enter Underlying Cause (Disease or injury that initiated c.  Events resulting in death) Last  Due to (or as a consequence of):							
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O, be exertise be exertise burial -	MENDED 23a,27,28a-f per me g883 9-10-08 vt    FEMALE: 23c. If yes, outcome of pregnancy   23d. Date of delivery							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1	Year						
that the de detached f	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause							
S, P.C	1 Yes 2 No 3 Probably 4 24a. Was an 124b. Were autopsy findi							
cords law require has been 2 should	24a. Was an autopsy find prior to completion death?  25 Place of Death (Check only one)							
tal Rec	1 Ves 2 No 1 Ves 2 No 1 Ves 2 No 26 Place of Death (Check only one)	2 No						
Vital Rechysician: The lability certificate la director, page	We examiner? Hospital: I was a Constraint of Documents of							
n of \alpha oding Phy h.  After the funeral of	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred							
ivisio	2 Accident Investigation 3 Suicide Could not be determined determined (Specific Hearing)  Residence  2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route or Town, State) 28f. Location (Street and Number or Rural Route or Town, State) 28f. Location (Street and Number or Rural Route or Town, State) 28f. Location (Street and Number or Rural Route or Town, State) 28f. Location (Street and Number or Rural Route or Town, State) 28f. Location (Street and Number or Rural Route or Town, State) 28f. Location (Street and Number or Rural Route or Town, State)	Number, Ci						
Division of <sup>1</sup> To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral								
To t with To t	and manner stated.  29c. License number  29d. Date signed (Month, Day,	Year)						
	formalted without MD O.C.M.E. A4GUST 15,	2008						
77	30. Name and address of person who completed cause of death (Item 23a)							
U	Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  31. Date filed (Month, Day, Year) 32. Registrar's Signature							
Sta Regist	trar ALIC 9 C 2000							
DHMH 17 Rev 1/20								

27332

	/Med Exami Funeral Director	
Baltimore, Maryland 21215-0036	permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anotes.	To Bo Completed by Europe Discoop

permit, Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "nat any Injury or other traumatic event, the Medica once.

Physician /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760, Regis

Registrar Certificate of Death										Reg.	No.					
	1. Decedent's Name	e (First, Middl	le, Last)									Death			3. Time of Death	
ian ical			l Eulert	400			T			Month August					1	
iner			n, give street and no Cott Drive	-			4b. City,		r Location Air	of Death				*	County	
	5. Social Security N 212-28-80		6. Sex 1⊠ M 2□ F	7. Age	(In yrs. las	st birthday) 7 Yrs.	If Unde Months	r 1 Year Days	If Under Hours	r 24 Hrs. Min.	8. Date of (Month,	Day, Yo		Cou	place (State or Foreign	n
	Usual Residence of			1		,					Dec.	6,	1930_	Bait.	.,Maryland	
	10a. State	10b. County	,		10c. City,	Town or Lo	cation								10d. Inside City Limits	3
ctor	Maryland	Har	ford Coun	ty	Ве	l Air									1 ☐ Yes 2 ☑ No	)
Funeral Director	10e. Street and Nur 863 E1			10f. Zip	Code 2101	5				10g. Citizen of What Country? United States of America						
ner	11. Marital Status		12. Was Dec			13.	Was Dece	dent of H	lispanic O	rigin? (Spe	ecify Yes or Rican, etc.)		14. Ra	ace - Ameri	can Indian,	_
y Fu	1 Never Marri		ried 1127 Yes If Yes, G	2□ No live	Kore Confl	an ict	1 ☐ Yes		Specify		r noun, oto.,		Spec	<sub>fv:</sub> White, etc. fv: White		
g g	3 Widowed		100.01	Dates:			dent'e Heu	al Occur	action			146		Business/Ir	adi tota	
Sete	I	cify only highe	nt's Education est grade completed			16a. Dece (Give life.	kind of wo DO NOT u	ork done ise retire	during mo: d)	st of work	ing	10			covement	
E O	Elementary/Seco	ondary (0-12) 12	College	(1-4or 5+	-)	se	elf en	nplo	ýed					ntrac		
Be Completed by	17. Father's Name Karl	(First, Middle, Eulert	, Last)								e (First, Mid			ime)		
2	19a. Informant's Na	ame/Relations	ship (Type, Print)			19b. Maili	na Address	s (Street			al Route Nu			n State Zi	n Code)	_
			Eulert/ w	ife					Driv		Bel Ai		•			
	20a. Method of Disp		2 □Pomoval fram	n Stato	20b. Plac	ce of Dispo	sition (Na	me of other plac	ce)	Augus	Date	20	c. Location	- City or T	own, State	
	1 Burial 2 Cremation 3 Removal from State Evants, Fund August 26, 4 Donation 5 Other (Specify) Chapel Bel Air 2008 Forest 1											, Maryland				
	21. Signature of Funeral Service Licensee  Peace and Afred Afred Funeral & Cren 2325 York Road timonium, Marylar													• 7		
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate															
1	Immediate Cause (	(Final	t only one cause on	each line	. I	2.11	IVP								Interval Between Onset and Death	
	disease or condition resulting in death)	""	a. Due to	o (or as a	conseque	nce of):	110		_							_
	Sequentially list conditions.  b. Metastatic Lung Cancer  Due to (or as a consequence oi).															
Examiner	Sequentially list con if any, leading to im cause. Enter Unde Cause (Disease or	conseque	equence on:													
хап	that initiated events resulting in death) I	5	c	o (or as a	conseque	nce of):										
calE			d.													
n/Medical																
	IF FEMALE: 23b. Was decedent		23c. If yes, or 1□Live		f pregnand Fetal d	eath 3	]Ectopic p	regnanc	у					ate of deliv		
Physicia	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No		gnant at ti	ime of dea	th 5[	Other (s	pecify) _				_		lonth	Day Year	
۲ P	Part II. Other signif	flcant conditi	ons contributing to	death but	not resulti	ng in the u	nderlying	cause giv	en in Part	I.	23e. D	id tobac	co use co	ntribute to	the cause of death?	
Completed by	Chron	iic C	obstruc	five	- Pu	IMO	na	4	Dist	ease	-   F	Yes	2□ No	3 ☐ Pro	bably 4 □Unknowr	1
plet											24a. W	as an utopsy	24b	. Were aut	opsy findings available ompletion of cause of	е
Sol											p 1□ Ye	erforme	d?	death?	2 □ No	
Be	25. Was case refer examiner?	red to medica	7.0					Lou		e of Death	Check on	l one				
2	1 Yes 227		Hospital: 1 28a. Date	Inpatien		R/Outpatier 8b. Time o		DA Oth 28c. Inju			me 5/				ify)	
tion	1 Natural 2 Accident	5 Pendir investi	ng (Mo	nth, Day		Injury	м .	Wor	rya≀ rk?  Yes 2.[_		28d. Descri	be now	injury occi	ırrea		
ifica	3 Suicide 4 Homicide  Could not be determined  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and City or Town, State)									et and Nun	nber or Rui	ral Route Number,	_			
Cert										state)						
dical	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (N									ned (Month	, Day, Year)	_				
	1	JE DA	MIS N	V)	)		T	)47	1934	+		8	125	1200	8	
	30. Name and addr	ress of person	who completed cau						01.		\\ - '~			•	<del>-</del>	
	31. Date filed (Mon	Jakis	5 227		Pour		nce	$\alpha$	WHI	n 046	MI	) 0	2120.	٠		_
tate trar		IUG 2 6	/2	cyistrar	J. Signatul	1	00									

			For State Registrar	State of Maryland	/ Depa	artment of l	Health an Death	d Mental Hy	rgiene 0 (	08 27333
H	Physici	an	1. Decedent's Name (First, Middle, Last)		T1			2. Date of D Month August		3. Time of Death 8;30P M
	/Medic	al	Francis  4a. Facility Name (If not institution, give s	C.	Ehart		or Location of D		4c. County of	
	Examin	er	Mandarin Hospice H			Harwood	_		Anne A	rundel
	Funeral Director		5. Social Security Number 6. Sax 216-01-0303	M 2 F 7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of Bi (Month, D July	22, 1915	9. Birthplace (State or Foreign Country) MD
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Maryl	tor	MD Anne Arun	del Seve	rn					1 ☐ Yes 2 🔀 No
	or 28s	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?
eath w	Funeral	8124 Quarterfield	Farms Drive  12. Was Decedent Ever in U.S.	13. \	2114	·	? (Specify Yes or N	U.S.A.	- American Indian,	
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "netural", or iteme 23a or 28a-f ehow event, the Madical Examinar must be notified at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		f Yes, specify Cul 1 ☐ Yes 2 💢 No		? (Specify Yes or N uerto Rican, etc.)	1	white, etc. White
Maryland 21215-0036 ad 2 should be filed within 72 hours at the and Mental Hygiene. 27 is marked other then "netural", or traumatic event, the Modical Exten	Completed	15. Decedent's Edu (Specify only highest grade	completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	e during most of	working	16b. Kind of Bu	siness/Industry	
212	d withi	Som	Elementary/Secondary (0-12)	College (1-4or 5+)	Sale	s Execut	ive		D.N.Owe	ns & Co. Inc.
2	should be filed within the Mental Hygiene. marked other then imatic event, the Mental th	Be	17. Father's Name (First, Middle, Last)					Name (First, Middl	e, Maiden Sumame	e)
3	s 1 and 2 should if Heelth and Men Item 27 is marke other traumatic	၉	Charles T. Ehart  19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Mailir	ng Address (Stree	Mary at and Number of	r Rural Route Num.	ber, City or Town,	State, Zip Code)
	od 2 stran		Mr Chrales W. Ehar							MD 21144
altimore,	Pages 1 ar		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ R	emoval from State	ce of Dispo netery, crer	sition (Name of matory or other pl		g.23,		City or Town, State
E E	permit. Pages Depertment of Important: If I eny Injury or one		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License		dowri	dge Memo	rial	2008	Elkridg	e, MD & Cremation
Ba	permit. Depertm Imports eny Inju		SILIMO SI	in KMO14	-					nie, MD 21061
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the death.	Do not ent	er the mode of dy	ying, such as car	rdiac or respiratory	arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consucted	ince of):		61		John J	9 days
) ·	uted J ansit	Examiner	Secuer itally list ronditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	ince of):			a Not	12 NY	, 0
760,0	ate be executed only sicien and the burlal-transit	icai Exa	resulting in death) Last	Due to (or as a conseque	ence of):			VIII	45/81	
89	Se de Se							$-V_{\circ}$	V.	
.O. Box	that the death certificate be executed ed by the attending physicien and deteched for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	eath 3	⊒Ectopic pregnan ☐ Other (specify)	cy		23d. Dat Mor	e of delivery nth Day Year
α,	8 6 6	ρ	Part II. Other significant conditions con	ntributing to death but not result	ting in the u	nderlying cause g	given in Part I.		tobacco use contr	ibute to the cause of death?
Records,	The law requir ate has been si bage 2 should l	Completed							opsy formed?	Vere autopsy findings available orior to completion of cause of leath?  ☐ Yes 2☐ No
/ita	ysicien: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	I h-h				Death (Check only	one)	
of	Physi rthis c ral dire	5	1 Yes 2 No		R/Outpatier 28b. Time o	" 3 DOX	and the second	ng Home 5 ☐ Re 28d. Describ	sidence 6 Other	er (Specify)   P
o	Attending Physicien: r death. ector: After this certific by the funeral director.	ation	1 Natural 5 Pending Accident investigation	(Month, Day Year)	Injury UNK	, W	ork? ∐Yes 2. MaiNo	7-7	11 A+	home
Division of Vital	i 를 들	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, st	reet, factory, offic	9		(Street and Numb own, State)	er or Rural Route Number,
	the Hospital hin 24 hours the Funeral the Funeral	edical (		sician: To the best of my know ner: On the basis of examination						
	To the within To the	Me	29b. Signature and title of certifier	-		29c. Disc	nse number	7/	29d. Date signed	(Month, Day, Year)
•			30 Name and addition of a second	empleted cause of death (Item)	23a) /Tunc	Print	1/10	<u> </u>	0/20	19)
	12		30. Name and address of person who co	1. 1			Mt Wasl	hington M	D. 21074	
2.	Sta Regist		31. Date filed (Month, Day, Year) AUG 2 6 20	32. Pagistrar's Signatu	ire	medi				

DHMH 17 Rev 1/2001

ORIGINAL

**ORIGINAL** 

DHMH 17 Rev 1/2001 OCME 2006 **Physician** /Medical Examiner

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, certificate has b rector, page 2 sl After this

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Vear 12:15a DENISE MARCELL FOSTER August 24 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6720 TOWNBROOK DR. BALTIMORE CO WOODLAWN 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🗓 F Hours 50 Director 213-80-1660 MARYLAND NOV. 27 1957 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 🗱 🗓 o Directo MARYLAND BALTIMORE CO BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examiner must once. 6720 TOWNBROOK DR APT D 21207 U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 200 No Specify. <u>م</u> 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DIETICIAN 12th grade HEALTH FIELD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROGER FOSTER LOIS FOSTER ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renardo Foster/Son 6720 Townbrook Dr., Apt D., Balto. Md., 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) 08-28-08 Arbutus Memorial BALTIMORE, MARYLAND Signature of Funeral Service Lie 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Part1. Enter the disease, or of mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List fully one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) etastatic months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physiclan and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 ☐ Other (specify) 9 □ Unknowh Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 1 🗆 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of a l 28b. Time of Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 2☐ Accident 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hou To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Security Baltimore MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

#### State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Reg. No.	2	0	0	8		2	7	3	3
to of Dooth					2	Tie		f Da	ath

Physician	
/Medical	
Examiner	

Director

Funeral

2

2

Elinor O'Connor Foster

2. Date o Month August

24, 2008 2:25 P. M

4a. Facility Name (If not institution, give street and number) Pickersgill Retirement Community

6. Sex

4b. City, Town, or Location of Death

Towson If Under 1 Year | If Under 24 Hrs.

Hours

Specify

4c. County of Death Baltimore County

**Funeral Director** 

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked outher than "natural", or Items 23a or 28a-f show any injury or other traumante event, the Medical Examiner must be notified at any injury or other traumante event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Usual Residence of Decedent

10c. City, Town or Location

7. Age (In yrs. last birthday)

84

8. Date of Birth (Month, Day, Year) Feb. 09, 1924

9. Birthplace (State or Foreign Baltimore, MD.

10d. Inside City Limits

Maryland

5. Social Security Number

214-20-8168

Baltimore County

1 □ M 2 🕅 I

Towson

1 ☐ Yes 2 No

White

10e. Street and Number

615 Chestnut Ave.

10f. Zip Code 21204

Days

Months

10g. Citizen of What Country? United States

11. Marital Status

1 Never Married 2 Married

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 No

14. Race - American Indian. Black, White, etc.

3 Widowed 4 □ Divorced

1 ☐ Yes 2X No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)

12. Was Decedent Ever in U.S Armed Forces?

16a Decedent's Usual Occupation

16b. Kind of Business/Industry

Specify:

Elementary/Secondary (0-12)

College (1-4or 5+)

(Give kind of work done during most of working life. DO NOT use retired) Treasurer

Bradford Federal Savings & Loan

Completed 17. Father's Name (First, Middle, Last) Be

William Harvey O'Connor, Sr.

18. Mother's Name (First, Middle, Maiden Surname) Rachel Oliver Hammen

19a. Informant's Name/Relationship (Type, Print)

Mr. Michael Foster, Sr. (Son)

e, or complications that caused the death. List only one cause on each line.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1111 Dulaney Gate Circle Cockeysville, MD. 21030

20a. Method of Disposition

Immediate Cause (Final

disease or condition resulting in death)

1 Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) 4 ☐Donation

Funeral Service Licensee

20b. Place of Disposition (Name of cemetery, crematory or other place)
Druid Ridge Cem.

Date August 2008 29,

Pikesville, Maryland

20c. Location - City or Town, State

**Physician** /Medical

burial-transit

as the

use

detached for

page 2 should be

has

the Hospital or Attending Physician: oin 24 hours after death.

To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After

signed by the attending physician and

Physician/Medical

Completed

Be

2

Certification:

Medical

the death certificate be executed

Division or Vital Records, P.O. Box 68760.

**Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last

21. Signature

	Peace UT Alternati 2325 York Road	ves Funera Timonium,	l&Cremat: Marylan	ion d	Ctr.3 <sup>P</sup> 21093	• A
10	t enter the mode of dying, such as cardiac	or respiratory arrest,		App	roximate rval Between	

Due to (or as a consequence of)

Due to (or as a consequence of):

Due to (or as a consequence of):

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2 ☑ No 9 Unknown

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 9☐ Unknown

3 Ectopic pregnancy 5 Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an

autopsy performed? Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 2 1No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

> 5 ☐ Pending investigation

6 Could not be determined

1 Inpatient 28a. Date of Injury (Month, Pay

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

A

2 ER/Outpatient 3□ DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 Natural

3 ☐ Suicide

2 Accident

4 Homicide

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. Licease number

29d. Date signed (Month, Daf, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

**ORIGINAL** 

08-06481 Georgia Farantos		Please Typ St	e or Print ate of Mary	i <b>n Bl</b> a	/ Departi	ment of	Health a	ure A	<b>All Copie</b> Mental H	<b>s Are Legi</b> ! ⁄giene		000 2722	
		State of Maryland / Department of Health and Mental Hygiene  1-For State  Reg. No.  Reg. No.  1.2 Date of Death								No. 4	008 2733 3. Time of Death		
Physician/	1.	. Decedent's Name (First, Middle,Last)						- 11	2. Date of Death Month D August 24, 2	ay Year	1424 hrs		
Medical Examiner		Georgia Emily Farantos  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location							cation of Death		4c. County of De	ath	
	4a	. Facility Name (if not institution 226 Chantrey Road	n, give street and	number)			Timoniu				Baltimore C		
Funeral	5.	Social Security Number	6. Sex	7. Ag	e (In yrs. last	birthday)	If Under 1		If Under 24Hrs	_	(MM/DD/YYYY) 9.	Birthplace (State or reign Manual and	
Funeral Director		212-98-1107	1 M 2 X F	_	36	Yrs.	Months	Days	Hours Min	12-05-	1971	Country Maryland	
	Us	sual Residence of Decedent	-23									10d. Inside City Limits	
any	10	a. State 10b. County			,,	own or Location	on					1 Yes 2 X No	
Strow	;L		timore		Tim	onium	10f. Zip Co	do		100	. Citizen of What 0	Country?	
Maryl Maryl state	Pure Arrange Supplied To Control of Supplied								U.S.A				
2 200  with the Maryland s 23a or 28a-f show a confided at once.		226 Chantry R		)eceden	t Ever in U.S.	13. Wa	s Decedent of	of Hispa	anic Origin? ( S	pecify Yes or No-	14. Race - A	merican Indian, Black,	
r death with or items 23.	1	Marital Status     Never Married 2	farried Armed	Forces	?	If Y	es, specify C	uban, I	Mexican, Puert	Rican, etc.)	White, et		
ler des			1 Ye vorced If Yes, Give		X No	h-man-	Yes 2 X				Specify: W		
ors after a mine	3	15. Decedent's Education (Sp	ecify only highest	rade co	mpleted) 1	16a. Deceden	nt's Usual Oc lost of workin	cupatio	on (Give kind of DO <b>N</b> OT use re		16b. Kind of Busine	ess/industry	
5 72 ho cal Ex		Elementary/Secondary (0-12	Colleg	e (1-4 or	5+)						Finan	00	
5-0036 ed within 72 hours lygiene other than "natu he Medical Exan		7. Father's Name (First, Middl	- Lost)	4		inves	tment	BY:0	8.Mother's Nan	e (First, Middle, M	aiden Surname)	<u></u>	
# # # # # # # # # # # # # # # # # # #	ນ	James Fara							Demetr	a Kokoli	;		
212 uld be Menta marke		9a. Informant's Name/Relation	ship (Type, Print)						and Number o	Rural Route Num	ber, City or Town,		
MD 42 sho tth and n 27 is aumati		Sophia Hobbs	/ Sister							Hunt Va	ley, MD	21030 tv or Town, State	
Fe, P		20a. Method of Disposition  1 X Burial 2 Cremati	n 3 Remov	al from S	Cr	ace of Dispor	ther place)						
MOP Pages ent of int: 1		4 Donation 5 Other	Specify:	7	St.							, Maryland	
Baltimore, MC permit. Pages 1 and 2 s Department of Health at Important: It item 27 injury or other traum:	1	21. Signature of Funeral Service	e Licensee		7.1	22.	Name and A					al Home, Inc.	
the state of the s	4	23a. Part I. Enter the disease,	2 11	at cause	ed the death.	Do not enter	the mode of	tori	such as cardia	or respiratory arre	Maryland est, shock, or heart	Approximate Interval Between Onset and	
Physician /Medical		failure. List only one cau	se on each line.						ication			Death	
aminer		Immediate Cause (Final disea or condition resulting in death			sequence of		101 11						
		Sequentially list conditions,	b						11 1				
	ne	if any, leading to immediate cause. Enter Underlying Cau	16 E	as a co	nsequence of	):							
	Examiner	(Disease or injury that initiate events resulting in death) Las	Due to for	as a co	nsequence of	·):							
and and	≂ ⊦	X UNPENDED	d	ED 23	3a,27,2	28a-f,	perMi	٤, و	g883 9/	1/08 TT			
Box 68760, e death certificate be exe the attending physician ed for use as the burial		IF FEMALE: 23b. Was decedent pregnant i	41 -	-	come of pregr		atal doath	3	Ectopic pre	anancy	23d. Date of d Month	elivery Day Year	
Box 68760, e death certificate by the attending physic ed for use as the bun	ian (	past 12 months?		ive birth regnan	i t at time of de		etal death Other (Spec						
30x death he atte	75 I	1 Yes 2 No 9		Jnknowr						220 Didt	obacco use contrib	ute to the cause of death?	
cords, P.O. B law requires that the d has been signed by the	by Phy	Part II. Other significant cor	ditions contribu	ting to de	eath but not resulting in the underlying cause gives in a second						res 2 No 3 Probably 4 ✓ Unknown		
ds, Faquires	Et									24a. Was		fere autopsy findings available for to completion of cause of	
COFC law re has be	Completed			1.						perfo	death?  Ves 2 No 1 Ves 2 No		
tal Rec		25. Was case referred to med	lical	26.Place of Death (Check only one)									
ital siciam is certi	Be	examiner?	Hospital:	Inp	atient 2	ER/Outpatie	ent 3 D	OA	Other <sub>4</sub> N	rsing Home 5	Residence 6		
Of VII	일	1 Yes 2 No 27. Manner of Death	28a	Date of (Month, D	Injury ay,Year)	28b. Time o	of Injury 2	-	ury at Work?	_	_	d drug &	
on endin sath.	tior		Pending FT	id 8	/24/08	Fnd 2	:00 pr	n	Yes 2 X No	alcoho		or or Pural Poute Number City	
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death. eral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	Certification:	3 X Suicide 6	28€		of Injury - At h			, office	building, etc.	or Town,	State 226 Ch	er or Rural Route Number, City <b>Lantrey Rd</b>	
Spital Spital Oi	Cer	4 Homicide					ourrad at the	time (	date and place.	and due to the car	use(s) and manner	as stated.	
Divisior  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	lical	(Check only 1 Certifying one) 2 Medical	Examiner:On the	basis of	examination :	and/or investi	igation, in my	opinic	on, death occur	ed at the time, dat	e and place, and a	40 10 110 0000 (1)	
29b, Signature and title of certifier							ed (Month, Day, Year)						
O.C.M.E. August 25, 2008								2008					
V LOUT		30. Name and address of pe		ed cause	of death (Ite	m 23a)	444.5		Stroot Dalti	more MD 242	01		
20		Patricia Aronica-P		19	nt Medical		111 P	enn S	oneet, Balti	more, MD 212			
St Regist	tate trar		6 2008	J. Keg	istrar's Signa	F Soft	23452						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 27338

Christopher Fakler	State of Maryland A	Department of Certificate of	Health and Mental H		200	8 2733
Physician/	egistrar I. Decedent's Name (First, Middle,Last)	Date of Death     Month     I	Day Year	3. Time of Death		
Medical Examiner	Christopher D. Fakl		4b. City, Town, or Location of Death	August 23,	2008 4c. County of Death	0732 hrs
4	a. Facility Name (if not institution, give street and number)  6 Rokeby Court	l l	Kensington		Montgomery	
Funeral		(In yrs. last birthday)	If Under 1 Year If Under 24Hrs	<b>⊸</b>		nplace (State or Foreign intry)
Director	213-80-5969   1XM 2 F	49 Yrs	Months Days Hours Min	July 16		nington, DC
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Locat	ion			10d. Inside City Limits
* *	Maryland Montgomery	Too. Oily, Town of Local	Kensington			1 Yes 2 X No
the Maryland a or 28a-f sh	100 Street and Number		10f. Zip Code	100	. Citizen of What Cour	try?
ith the Maryland 23a or 28a-f show notified at once.	6 Rokeby Court		20895	Ţ	Jni <u>ted</u> Stat	es
or items 23 must be no	11. Marital Status 12. Was Decedent		is Decedent of Hispanic Origin? (S es, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
er deat r. musi Fun		X No	Yes 2 X No specify:		to	
urs aft tural' amine	15. Decedent's Education (Specify only highest grade con	npleted) 16a. Deceder	it's Usual Occupation (Give kind of		Specify: Whi 16b. Kind of Business/I	
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exan	Elementary/Secondary (0-12) College (1-4 or	5+)	ost of working life. DO NOT use ret	ired)		
withir part of the	12 17. Father's Name (First, Middle, Last)	Vc	olunteer	e (First, Middle, M	Charitabl	.e
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medical	Herman M. Fakler, Jr.			iz Rodrig		
21; nould band Men id Men is mar tite eve	19a. Informant's Name/Relationship (Type, Print )		g Address (Street and Number or	Rural Route Numb	per, City or Town, State	
MD and 2 sho afth and 2 sho afth and raumati	Beatriz R. Fakler/Mother		ceby Court, Kens:	ington, [	Mary Land 20 20c. Location - City or	7895 Town, State
2 3 5 5 5	1 Burial 2 X Cremation 3 Removal from St	ate Montgomer	her place) Aug	ust 26,	D - 1 1-	M11
Baltimore, permit. Pages I ar Department of Het Importants: If ite injury or other tr	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	I Cromotor	enium Inc 1400	O	Bethesda,	Maryland
Balt permit. Depart Import injury	21. Signature of Funeral Service Licensee  23a. Part I. Enter the disease, or complications that caused	M00198 30	bert A. Pumphrey <u>OWestMontgomery</u>	Ave. Ro	ckville, M	D 20850-2805
Physician /Medical	failure. List only one cause on each line.			or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death)  Hypertensive C  Due to (or as a cons	ardiovascular Dise	ase			Death
The same of the sa	Sequentially list conditions, b					
iner	if any, leading to immediate  Due to (or as a cons	equence of):				
red Insit	(Disease or injury that initiated events resulting in death) Last   Due to (or as a cons	equence of):				
c 68760, r certificate be executed ending physician and use as the burial - transit ciant/Medical Exi	d.  UNPENDED X AMENDED 4a	,perME, g88	2 8/26/08 TT			
760, cate be physicily he buricher Med	IF FEMALE: 23c. If yes, outco	me of pregnancy			23d. Date of deliver	y
Box 6876( ne death certificate the attending phy ned for use as the b hysician/Me	23b. Was decedent pregnant in the past 12 months?	2	etal death 3 Ectopic pregr ther (Specify)	nancy	Month	Day Year
). Box the death coby the attentiched for us	1 Yes 2 No 9 Unknown g Unknown					
P.O. s that the greed by a detache	Part II. Other significant conditions contributing to deal	h but not resulting in the	underlying cause given in Part I.	23e. Did tol	acco use contribute to	the cause of death?
ords, P.C. w requires that s been signed should be det	Cirrhosis of the Liver			24a. Was a	in   24b. Were a	utopsy findings available
Records, The law requires freate has been sign, page 2 should be Completed				autops	med? death?	completion of cause of
tal Rection: The certificate ector, page	25. Was case referred to medical		26.Place of Death (Chec	1 Yes 2	2 No 1 Y	es 2 No
Vital ysician ysician directo	examiner?	ent 2 ER/Outpatier	loui		Residence 6 🗸 Othe	r: Scene
n of Vil ding Physic L. After this funeral dire	27. Manner of Death 28a. Date of Inj (Month, Day)	ury 28b. Time of Year)		28d. Describe h	ow injury occurred	
ivision or Attend after death. Director: Jin by the tifficatio	2 Accident Investigation	At home form etc.	1 Yes 2 No	28f Location (S	treet and Number or R	ural Route Number, City
Division of Vital Records, spital or Attending Physician: The law requirement of the death.  The and Director: After this certificate has been signed by the funeral director, page 2 should be destricted by the funeral director, page 2 should be certification: To Be Completed	3 Suicide 6 Could not be determined (Specify)	njury - At nome, farm, str	eet, factory, office building, etc.	or Town, St		star reduce reamber, only
O file	29a. Certifier 1 Certifying Physician: To the best of n	ny knowledge, death occi	urred at the time, date and place, ar	nd due to the cause	e(s) and manner as sta	ted.
To the How within 24 h. To the Fun completely	one) 2 Medical Examiner: On the basis of examiner and manner stated	amination and/or investig	29c. License number	at the time, date a	29d. Date signed (Mo	
2	29b. Signature and title of certifier		O.C.M.E.		August 23, 2008	
T	30. Name and address of person who completed cause of	death (Item 23a)				
10	Donna M. Vincenti, MD Assistant Medi	cal Examiner 11	1 Penn Street, Baltimore, I	MD 21201		
State Registrar	31. Date filed (Month, Day, Year) AUG 2 5 2008 32. Figistr	ar's Signature	anti			

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State of Maryland / Department of Health and Mental Hygiene 2008

amend #6 Per FH G882 8/26/08. IH
Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Garrett **Physician** 24, 2008 4c. County of Death 2008 Donald Auaust /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City**  Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** ဖြ 212-44-5519 9-27-1945 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County show 1 Yes 2 □ No notified at M Director altimore 28a-f 10g. Citizen of What Country? 10f. Zip-Code 10e, Street and Number ö ue ckert Ave must be ala14 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11. Marital Status Pages 1 and 2 should be filed within 72 hours after Yes 2 LNO 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 1 No Specify: If Yes, Give Year or Dates: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than ounselor State of <u>Hyrs</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **Baltimore, Maryland** Be Department of Health and Mental *Sarrett* Dele aver alaman ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rueckert Baltimure MD 21214
20c. Location - City or Town, State Ave 20a. Method of Disposition Garrett Important: If item 27 any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8.30.2008 Baltimore, MI) Memorial 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaugno C. Greene Funeral Services 21. Signature of Funeral Service Licensee 4905 York And Bultimore, MD 23a. Part 1. Enter the disable, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 18 days Physician /Medical **Examiner** APPROVED THE BICAL EXAMINER Dneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of burial-transit that initiated events Due to (or as a consequence of): CERTIFICATION resulting in death) Last 68760, physician Physician/Medical the as Box ( 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 2 No ed by the at detached f P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş Records, transplantation 1 ☐ Yes 2 No 3 Probably une Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 🗌 Yes Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ည hours after death. 28d. Describe how injury occurred 27. Manner of Death
1 X Natural
2 Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 6 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) completely within 2. 29d. Date signed (Month, Day, Year) 29c. License number -29b. Signature and title of certifier August 24, 2008 Stanna Hoguen, M.D. RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peloquin, M.D. 600 North Wolfe St. Baltimore, MD, 21287 Joanna 2008 32. Re strar's Signature State Registrar

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68760,
Box
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2:00P 8-21-2008 Eileen S. Graves /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Balto. Parkville 0akcrest If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min 1 □ M 2 🗓 F 9-201930 Md. Director 213-26-0857 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10h County 10c. City, Town or Location 10d Inside City Limits ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Balto Overlea Md. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21206 USA 6017 Mannington Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 No White Specify 3 ₩ Widowed 4 Divorced Year or Dates: er than "nature , the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Southern States Secretary ?7 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles V. Smith Frances M. Barry 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 6017 Mannington Avenue Overlea, Md. 21206 James M. Graves, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If ite any Injury or o ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 8-26-2008 Glen Burnie Cedar Hill 21. Signature of Funeral Service License 22. Name and Address of Facility Schimunek Funeral Home Stephene 9705 Belair Rd. Nottingham, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** cerebrouscular disease -nd stage disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duel to for as a consequence of: sician and certificate be executed Exami Due to (or as a consequence of): attending physician for use as the buris Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1□ Yes Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗔 🚜 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Mann of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOCO Walther Blid Partville, MD 21234
Registrar's Signature 2/05ha 31. Date filed (Month, Day, Year) State AUG 2 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** 4a. Facility Name (If not institution, give street and number) 06:40 AM /Medical 08 4b. City, Town, or Location of Death 4c. County of Death Examiner B. Himore Bultima umms 5. Social Security Number 6. Sex. 1 2 M 2 □ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months Days 48 Yrs Director 224-08-68 6/13/60 Virginia Usual Residence of Decedent show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1

Yes 2

No Prince George's appa Ma-1600 Mn 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 20774 items 23a Bowie P... 2012 U.S. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s any injury or other traumatic event, tra Medical Examir actionat any injury or other traumatic event, tra Medical Examir actionate ponee. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces 1 ☐Yes 2 No If Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 No ģ Specify: 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) JK Moving Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Carroll Gillison, Sr. Lavinia Tate 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert C. Gillison/Brother 10497 Walkers Lane, King George, VA 20b. Place of Disposition (Name of cemetery, crematory or other place)
Milton Valley
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/23/08 4 ☐ Donation 5 ☐ Other (Specify) Berryville, VA 22. Name and Address of Facility Cartwright Funeral Home 21. Signature of/Funeral Service-Licensee 232 E. Fairfax Lane, Winchester, VA 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shrick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Due to (or as a consequence of): P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physiciar 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Xes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 **X** No 1 ☐ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ∏No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NPI: 1235334681 8/17/158 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimon, MD

7

State Registrar

Hegistrar AUG 2 6 2008

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

21201

Registrar
DHMH 17 Rev 1/2001

UMA

AUG 2 6 2008

31. Date filed (Month, Day, Year)

210

BUSINESS

32. Registrar's Signature

DRIVE

3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 7:40 p.<sup>™</sup> August 2008 CONSTANTINE GREEN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore **Baltimore** Charlestown Retirement Community 8. Date of Birth August 14,1915 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Hours Months Days 212-38-6610 93 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2√No Be Completed by Funeral Director Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21228 709 Maiden Choice Lane 12. Was Decedent Ever in U.S.
Armed Forces?

XX Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: WW 11 1 ☐ Yes XX No White 3 ☐ Widowed 4XX Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chief Petty Officer U.S. Navy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gologia Sukowski Sergey Green ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3021 Weaver Ave. Baltimore, Maryland 21214 Penny Troutner Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Trinity Cemetery 8-27-08 Elkridge, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 21. Signature Funeral Service 6500 York Road Baltimore, Maryland 21212 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificat completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Evans 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 3. Time of Death 2. Date of Death s Name (First, Middle, Last) Day Year **Physician** 2008 9:00 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5428 Lynview Avenue Baltimore
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 3irthpiac Country) MD 7. Age (In yrs. last birthday **Funeral** Days Hours Min Months 1**X** M 2□ F 212-52-7343 59 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is more to be published in the marked other than "natural". YEYes 2 □ No Director MD n/a Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 USA 5428 Lynview Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. SpecifyAfrican-American 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give à 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry State of Maryland Elementary/Secondary (0-12) College (1-4or 5+) Correctional Officer 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ Shirley Brown <u>Randolph Glasco Sr.</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5428 Lynview Avenue, Baltimore, MD 21215 Shirley Belton/Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 8-27-08 King Memorial Park Woodlawn, MD 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility Whie Funeral Home P.A. of Balto. Co. 9200 LibertyRoad, Randallstown, MD 21133 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, After this certificate has been signed by the attending physiclan funeral director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 nesidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Beath 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the desired for the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Si

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ORIGINAL

21208

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 2008 3:30 P.M 24, August Robert Rhoten Grimes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospital Center Westminster 8. Date of Birth (Month, Day, Year Aug. 9, 19 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** XXM 2□F Months Days Hours Director 215-30-3628 76 1932 Maryland Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene. other than "natural", or Items 23a or 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show adleal Examiner must be notified at 10b. County 1 Yes 200 No Maryland Carroll Directo Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 2030 East Deep Run Road 21102 America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo Specify. Specify: White ģ 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Materials Inspector State of Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item Z7 Is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Wilson Grimes Anna Marie Rhoten 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilda M. Grimes (Wife) 2030 East Deep Run Road, Manchester, Maryland 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Aug. 28, 4 Donation 5 Dotter (Specify) David's Cemetery 2008 Hanover, Pennsylvania 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. ignature of Funeral Service Liv 3296 Charmil Drive, Manchester, Maryland 21102 2. a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner ccubitu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ While Scienosis 1 Yes 2 No 3 Probably 4 Unknown Completed Hypoalbumenuk 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2□ No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Depatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No 2 ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this or completely filled in by the funeral dir Certification: To 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide t 🖵 😅 Titying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) D-0054218

State Registrar

08-06459 Dan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Marvland / Department of Health and Mental Hygiene

Daniel Green	1- 1	S For State	state of Maryland	Depart / Certi:	tment of <i>ificate of</i>	Health and Death	Mental H	Reg	j. No.	200	8 2734
Physician	Re	gistrar Decedent's Name (First, Mid	dle,Last)				To the	Date of Death     Month	Day Yea		Time of Death 1539 hrs
Physician Medical Examine	er	Daniel Gilbert	Green				tion of Dooth	August 23,	2008 4c. County		
	48	. Facility Name (if not institut	tion, give street and number)		1	b. City, Town, or Glen Burnie			Anne Ar		17 -00
		Baltimore Washington		ge (In yrs. las	st hirthday)	If Under 1 Yea		s. 8. Date of Birt	(MM/DD/YYY)	9. Birthpl	ace (State or
Funeral Director		Social Security Number 217–17–49/43	6. Sex 7. Ag	28	Yrs	Months Day	1.0		)	Countr	ry) MD
Bitcotor		sual Residence of Decedent								10	Od. Inside City Limits
any	_	Da. State 10b. Coun	ty	10c. City, T	Town or Locat	ion					Yes 2 X No
*	۱.	MD Anne	Arundel	Seven	n	10f. Zip Code		10	g. Citizen of W	hat Country	P
1 at o	Director	0e. Street and Number									
with the Mary		1858 Hawk Court	12. Was Deceder	at Ever in 11 S	s 13 W	21144 as Decedent of H	spanic Origin? (S	Specify Yes or No			n Indian, Black,
death with the Maryland or items 23a or 28a-f show must be notified at once.		Marital Status     Never Married 2	Armed Forces	?	If Y	es, specify Cuba	n, Mexican, Puer	to Rican, etc.)		ite, etc. Δ <b>fri</b> car	n-American
er dea		21	Divorced If Yes, Give Year	2 X No		Yes 2 X N			Specify		
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15-0 filed w Hygin d other		17. Father's Name (First, Mid Ronald Green	dle, Last)				Roonie A	Johnson_			
2121 ould be fi Mental marked ic event,	To Be	19a. Informant's Name/Relati	ionship (Type, Print )				eet and Number o	r Rural Route Nu		own, State, 2	Zip Code)
2 shout and N	-	Bonnie A. Gree			905 E	. Watervil	le Road, N	It. Airy, N	1) 21 771 20c. Locatio	n - City or T	own, State
e, N I and Health	ı	20a. Method of Disposition		State 20b.	Place of Dispo crematory or o	osition (Name of o other place) norial Par	cemetery,				
nor ages ent of nt: If	- 1	1 X Burial 2 Crema 4 Donation 5 Other	er Specify:	Art				-29-08		us, MD	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	-	. F	ina Licensea	011	- 22	Name and Addre	ess of Facility [Wy]	lie Funera	L Hame P.	A. of F	Balto. Co
E P P E		DIGNEY	e, or complications that caus	MICH death	Do not ente	the mode of dyir	yRoad Ran ng, such as cardia	rdal Istown ic or respiratory a	rest, shock, or	heart	Approximate Interval Between Onset and
Physician		23a, Part I. Enter the diseas failure. List only one ca	e, or complications that caus ause on each line.	ea pe dean	o o med d	ovaccu1s	r diseas	s e			Death
Medical .aminer	١	Immediate Cause (Final discorrection resulting in dea		ensive	cardi	ovascula	ii uisea.	<u> </u>			
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	ě	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence o	of):						
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cuted	Ex	events resulting in death) I	d								
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687 certific	ian/	past 12 months?		n nt at time of c	death 5	Other (Specify)					
Box 68760 e death certificate in the attending physed of for use as the bh	Physician/Me	1 Yes 2 No 9					i Deal	23e Di	n tohacco use o	contribute to	the cause of death?
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rds requi	ee								topsy erformed?	death?	completion of cause of
eco he law are has	Completed	-							es 2 No	1 🗸 Y	es 2 No
A. T.	Ö	25. Was case referred to n	nedical				Other	lursing Home 5	Residence	6 Othe	er:
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safter death.  The Director After this certificate has been signed by lied in by the funeral director, page 2 should be detack lied in by the funeral director, page 2 should be detack.	10	examiner?	0		✓ ER/Outpa		Injury at Work?		be how injury o		
of ing Pt After Unera		27. Manner of Death 1 X Natural 5	28a. Date o (Month,	of injury Day,Yeer)	280. 11116	1	Yes 2 N	0			
Division of N pital or Attending Phy ours after death. reral Director: After t	Certification:	2 Accident	Pending Investigation	of Injury - A	t home, farm,	street, factory, of	fice building, etc.	28f. Location	on (Street and I	Number or F	Rural Route Number, City
livisior  I or Attenc after death Unrector: d in by the		3 Suicide 6	determined (Specify)						n, State)		
			(	t of my knowl	ledge, death o	occurred at the tir	ne, date and place	e, and due to the	cause(s) and m	anner as sta	ated. the cause(s)
To the Hos within 24 h	Medical	(Check only one) 2 ✓ Medic	ying Physician: To the best cal Examiner:On the basis o and manner st	of examination	n and/or inves	stigation, in my of	on lon, death each	irred at the time, t			fonth, Day, Year)
To Too	Me	29b. Signature and title of					icense number			t 24, 200	
		160, morre	. Dre Greek				D.C.M.E.				
			person who completed caus	se of death (I	Item 23a)	1 Penn Stree	et Baltimore	MD 21201			
D		Margarita Korell	100.00	gistrar's Sign		Cilii Gilet					
	Stat	AUI	g 2008 32 6 2008	Column S Sign	15	greek!					
Regi	EUG	<u> </u>				7.00					

**ORIGINAL** 

Amend #17 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** GOLDMAN 4100 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country)
 POLAND 8. Date of Birth (Month, Day, Year) 03/29/1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2**X**F 219-60-3735 81 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Modical Examiner must be retified at once. 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21208 USA 8911 REISTERSTOWN ROAD by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 14. Bace - American Indian. 1 ☐ Never Married 2 🕅 Married WHITE 1 Tyes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN Abraham FINKELSTEIN CHARNA KRAUSE ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ONE WOODSYDE PLACE, OWINGS MILLS, MD 21117 MORRIS GOLDMAN / SON 20b. Place of Disposition (Name of LUBAWITTZ'errous ACHT ART) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 08/25/2008 | ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Par/1. Enter the disease or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ned by the a I □Yes 2 □ No 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si , page 2 should t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? **Director:** After this certificated in by the funeral director, page 1 ☐ Yes 2 ☐ No 2 ONo 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 6 Hother (Specify) HOSPICE Other: 4 Nursing Home 5 Residence 1 ☐ Yes Certification: To 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in musciples, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Y

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 4a. Facility Name (If not institution, give street and number) 22, 2008 11:00 P4 August /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Manor Care of Dulaney Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 30,1926 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours 171-20-1124 Director 81 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b Counts 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 📉 No Director Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 7 7704 Bloomfield Road 21601 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★★ 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Insurance Industry Insurance Broker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mills Grundy 2 James Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7704 Bloomfield Road Patricia Grundy Easton, Maryland 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 8 permit. Pages Department of Important: If It any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Morris Cemetery <del>4</del>-29-2008 Phoenixville, PA 21. Signature of Puneral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 5/2 23a. Part1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Immediate Cause (Final disease or condition resulting in death) dementia and stage **Physician** 5 YVOT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the arriving Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been si page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2☑No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mian-OK 031865 20 30. Name and address of person who correleted cause of death (Item 23a) (Type, Print) 821 N Enton street Baltimore md. Mian-Pour Kitung Ron 206 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 2 6 2008

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Ellen August 23, 2008 7:25 A M Richardson Glueck /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Manor Care Towson Baltimore Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 9, 1919 Birthplace (State or Foreign
Country) **Funeral** Days 1 □ M 2**X**) F Months Hours 009-05-3620 89 June Massachusetts Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f si other traumatic event, the Medical Examinar must be muttined Pa. Bradford Towanda Funeral Director 1 ☐Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 200 Ann St. 18848 USA Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "naturar", or Items 23; 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Α. Sumner Richardson Lila Frances Adams ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha G. Eskin / Daughter 1610 Jeffers Rd. Towson, Md. 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If Ite any injury or ot once. 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Hillton Service Co. 4 Donation 5 Other (Specify) B-25-08 Towson, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phermonia **Physician** Aspiration disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Disease Oron Ary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transi Due to (or as a consequence of) P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of page 2 s 24a. Was an death? 1 ☐ Yes 2 ☐ No certificate perform 1 ☐ Yes 2 3 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ins DO0 577 40 August 25, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8501 Rel TOWNSON. Lasalle 21286 wile, MD Ste 102 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** GRAHAM MES /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Baltimore 5639 Oregon Ave. Arbutus 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 24, 1938 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours Min 1X M 2 □ F 163-32-1884 Pennsylvania 69 Nov. Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Show d other than "natural", or items 23a or 28a-f show event, the Mydical Examiner must be portified at Director 1 ☐Yes 2 ☐No Md. Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 5639 Oregon Ave. USA Completed by Funeral filed within 72 hours after death Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify. SpecifyUhite 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SSA Facilities Management h and Mental Hygie 7 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill f Health and Mental H Be James R. Graham Parker Jane 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health at Important: If item 27 is any Injury or other trau once. Mr. John Graham/ Brother 10500 Leslie Dr. Raleigh, NC 27615 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State New Bethlehem Cem. 8-27-08 New Bethlehem, Pa. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funer 22. Name and Address of Facility
RUCK Towson Funeral Home
1050 York Rd. Towson, Md Service Licent 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Extending to immediate cause. Closease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ģ Month Day Year 5 Other (specify) P.O. 9 Unknown à s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 \sum Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 5 Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 5 Pending investigation 1 Natural death. illed in by the fi 1 ☐ Yes 2 No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 ☐ Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cand manner street. Medical ination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and titl

th, Day, Y

6 2

ss of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

08-06457 John Howell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

ın Howeli		State of Maryland / Department of Hea		No. 2008 2735
Physician	<b>/</b> 1	legistrar 1. Decedent's Name (First, Middle,Last)	·2. Date of Death Month	3. Time of Death
edical Examine		Tuesday Harris (i) Not institute of great and	y, Town, or Location of Death	4c. County of Death Prince George's
Funeral	5	Laurel Regional Hospital Lau  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	nder 1 Year If Under 24Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		085-46-8308 1XM 2F 55 Yrs.	nths Days Hours Min. Jan 27,	0
any.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 Yes 2 X No
	١	MD Anne Arundel Laurel  10e. Street and Number 10f.	Zip Code 10g	g. Citizen of What Country?
the Mary a or 28a	Ulrector	3565 Ft. Meade Rad, #312	0,22	U.S.A.
	ᇛᅥᇃ	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dec 14. Was Decedent Forces? 15. Was Decedent Forces? 16. Yes, sp	edent of Hispanic Origin? (Specify Yes or No- ecify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
after des	by Fu	Widowed 4 Divorced or Dates 1971-72 1 Yes	2 No specify:	Specify: White
15-0036 filed within 72 hours after of Hygiene of other than "natural", of the Medical Examiner in the	jed -	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Us during most of	ual Occupation (Give kind of work done working life. DO NOT use retired)	100. Kind of business/moustry
0036 Within 7 iene. or than	Completed	10 none	18.Mother's Name (First, Middle, M	none aiden Surname)
2 e g s = 1	Be C	17. Father's Name (First, Middle, Last)  John Innis Howell, Sr.	Dorothy A. Nel	son
mD 2121 and 2 should be fi tealth and Mental I tem 27 is marked traumatic event,	٥	0.55	ress (Street and Number or Rural Route Number of Rural Route Numbe	
tra de an		Dorothy Howell /mother 3565 Ft  20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State crematory or other pl	Name of cemetery, Date	20c. Location - City or Town, State
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tra		4 Donation 5 Other Specify: / Maryland Vet		Crownsville, Maryland
Balt permit Depart Impor injury		M00773 313	and Address of Facility Idson Funeral Home, P Talbott Ave. Laurel,	Maryland 20707-4389
Physician 'Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the more failure. Ust only one cause on each line.		
kaminer		Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive Atherosclerotic Cardiova  Due to (or as a consequence of):	Scorar Disease Complicating Frepati	O OIITIOSIS
	Ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
		cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		
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760, cate be e			a	23d. Date of delivery  Month Day Year
Box 687 e death certific the attending p ed for use as th	Physician/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal di 4 Pregnant at time of death 5 Other	eath 3 Ectopic pregnancy (Specify)	Wichtin Buy 1868.
, P.O. Box 68760, res that the death certificate be executed signed by the attending physician and be detached for use as the burial - transit	Phys	1 Yes 2 No 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the unde	,	obacco use contribute to the cause of death?
ires that the signed by	d by	chronic alcohol abuse	1 Yes	an   24b. Were autopsy findings available
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death.  reral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	Completed		autop perfo	prior to completion of cause of death?
Rec n: The rtificate or, page	e Con	25. Was case referred to medical	1 ✔ Yes 26.Place of Death (Check only one)	2 No 1 Yes 2 No
Vita	P P	examiner?  Hospital: Inpatient 2 FR/Outpatient 3  7 Manager of Death  28a Cate of Injury 28b. Time of Injury	DOA Other Nursing Home 5  28c. Injury at Work? 28d. Describe	Residence 6 Other:
on of anding Phath.		1 Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	
ivisical or Atter der Directo	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, farmation (Specify)	actory, office building, etc. 28f. Location ( or Town, 8	Street and Number or Rural Route Number, City State)
프랑토프		29a. Certifier A Cartifician Physician: To the best of my knowledge death occurred	at the time, date and place, and due to the cause	se(s) and manner as stated.
To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.  29b. Signature and title of certifier	in my opinion, death occurred at the time, date 29c. License number	29d. Date signed (Month, Day, Year)
~	-	Ann T Sauthaull min	O.C.M.E.	August 24, 2008
211		30. Name and agricess of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 111 F	Penn Street, Baltimore, MD 21201	
St	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature		
Regist		AUG 2 6 2008 Consult South	OCME	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - For State Registral Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3:40PM Month Humust **Physician** Frederick Irvin Huber ZOOX /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 18, 1 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Hours Min **Funeral** Days Months 1 X M 2 □ F Maryland 1920 217-05-2525 88 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10h County 10a. State show If marked other than "natural", or items 23a or 28a-f shot traumatic event, the Wulfail Eventium rust be notified at 1 ☐ Yes 2 ☐ No Funeral Director Gwynn Oak Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with **USA** 21207 6825 Campfield Road Apt. 11-Q 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No. 1943 If Yes, Give Year or Dates: 1945 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗓 No White Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Steel Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emma Kraft Edward W. Huber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6825 Campfield Road Apt. 11-Q Gwynn Oak, MD 21207 Edna Louise Huber, Wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. | 08/23/08 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor romou 23a. Part 1. Enter the disease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner to if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Box 68760 physician a Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Fctopic pregnancy Year Month Day 5 ☐ Other (specify) cate has been signed by the capage 2 should be detached by ö 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 ☐Yes 2 ☐No 26. Place of Death (Check only one) Be ( 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manuer of Death 28b. Time of 5 Pending investigation after death.

Director: Aff
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P. Hospital

within 24 hours a

To the Funeral C

completely filled 104 State

29b. Signature and title of certifie

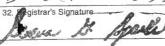
N. CALVERT

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DSCOKE DAVIT

31. Date filed (Month, Day, Year) AUG 2 6



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician /Medical 4c. County of Death b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner torc Birthplace (State or Foreign Country) If Under 1 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday Social Security Number 3 Yrs. **Funeral** Min Months Days Hours 1 12 M 2 □ F Kentuck 0/25 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is anaked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evan her must be multipled at 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21084 ral Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 1 Yes 2 □ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) jenero 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Plint) Road 20a. Method of Disposition

1 Burial 2 Cremation 3 F

4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 3 Removal from State 21. Signature of Funeral Service Licensee Evans Fineral Chapel + CREMATION SERVICES-Partville 23a. Par 1. Enter the disease, ir complications that caused the shock, or heart failure. Lift only one cause on each line. Approximate Interval Between Onset and Death complications that caused the leath. Do not enter the mode of dying, such as cardiac in respiratory arrest Immediate Cause (Fin hodisease or condition resulting in death) 1212 Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the t IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 🗆 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dether (Specify) ASSIS Led 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred MUCH 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 1172 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of Lerul er 29d. Date signed (Month, Day, Year) an Name and address of person who completed cause of death (Item 23a) (Type, Print) WINCAN 615.W. MACPLA

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

AUG 2 6

2008

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician**  $P_{M}$ Sylvia 4:40 Hare 21, 2008 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Ivy Hall Nursing Home Middle River If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, October 3, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min. 1 □ M 2 🛛 F Maryland 72 Yrs 216-32-1404 1935 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Tem 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Owings Mills 1 ☐ Yes 2 X No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 10 Sierra Circle U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █️No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No If Yes. Give Specify Completed by Specify: White 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell I. Ament Helen B. McDonald ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Steele/Daughter 3541 Moultree Place, Nottingham, MD 21236 permit. Pages 1 a
Department of Her
Important: If item
any injury or othe
once. 20b. Place of Disposition (Name of Glen Have place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/25/08 Glen Burnie, MD Park 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Evans Fureral Factorapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 2. a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he if failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Faithere to **Physician** year /Medical Due to (or as a consequence of): Examiner Maly nan cy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed esions LYTIC Due to (or as a consequence of Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Natural
2 Accident 5 Pending investigation death. 1 ☐Yes 2 ☐No To the Funeral Director: , completely filled in by the f 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0061907 Name and address of person who completed cause of death (Item 23a) (Type, Print) 24 Mace Avenue 0 Butimore MD 21221 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 23, 2008 11:15 PM August John (aka Jack) Heaney /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Stella Maris If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year **Funeral** Months Days Hours Min. 1 ★ M 2 T F 112-16-3940 July 28, Director 80 1928 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, I'm Wedical Evanthar must be notified at 1 Yes 2 No Director Maryland Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21217 1901 Linden Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates: 1950-52 1 ☐ Yes 2 🖾 No Specify þ Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any Injury or other traumatic event, Item Many Injury or other Elementary/Secondary (0-12) College (1-4or 5+) Accounting Certified Public Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Loretta Cullen John W. Heaney, Sr. P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1901 Linden Avenue; Baltimore, MD 21217 Wife Catherine Heaney 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest 8/28/2008 Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service License 1901490 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed sician and burial-trant Due to (or as a consequence of) Box 68760, Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page The performed' certificate Vital 1 □ Yes 2**X** No 1 ☐ Yes 2 No or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 👿 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Division of funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation To the Hospital or Attendi within 24 hours after death, To the Funeral Director; A 1 🗆 Yes 2 No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide

AUGUST

completely State

DR. ERNESTINE WRIGHT 31. Date filed (Month, Day, Year)

and manner stated.

Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 Registrar's Signature

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

AUG 2 6

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

Registrar

		Please Type or Print in B	lack Ind	delible Ink.	Ensure A	All Copies	Are Legib	ole.	
State of Maryland / Department of Health and Mental Hygiene  1 - For State Registrar  Certificate of Death  Reg. No. 2 0 0 0 2 7 0 5 0									
		ith 20	08 27356						
Physicia	ın	1. Decedent's Name (First, Middle, Last)  William W. Herold Sr.				2. Date of Dea	t 22,20	008 8:28 A M	
/Medic	-	4a. Facility Name (If not institution, give street and number)		4h City Town o	r Location of Deat		4c. County of		
Examin	er	Franklin Square Hospital		Roseda	_			ltimore	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth	) ( Year)	9. Birthplace (State or Foreign Country)	
Director		268-38-1051 <sup>¹ᡚм 2□F</sup> 65	Yrs.	Wortins Days	Tiours Willia	April	20,194	43 MD	
and *	}	Usual Residence of Decedent           10a. State         10b. County         10c. City,	Town or Lo	cation				10d. Inside City Limits	
Maryli f sho ied at	ō	MD Baltimore E	ssex					1 ☐ Yes 2 No	
r 28a-	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of W	/hat Country?	
h with	a D	735 Corby Road		2122	21		USA		
ems ?	Funeral	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	3. 13. \	Was Decedent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race Black	e - American Indian, k, White, etc.	
or it	by Fu	1 □ Never Married 2 □ Married 1 □ XYes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced 1 □ XYes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2 <b>X</b> No	Specify:			White	
hours tural'	q pe	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education	16a. Deced	dent's Usual Occup	ation		16b. Kind of Bu	siness/Industry	
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12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type. Print) Randy Herold / son	19b. Mailir	ng Address (Street	and Number or A 7id Road	d Wilmi 3 Wilmi:	ngton I	State, Zip Code) Delaware19810	
1 and Healt tem 2		20a Method of Disposition 20b. Pla	ace of Dispo	sition (Name of		Date		City or Town, State	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State Ba	yview yview	matorý or other plac v Cremat	ory 8/2	3/08	Baltin	more MD	
mit. F partm portar / Injui		21. Signature of Funeral Service Licensee	22	2. Name and Addre	ss of Facility	300 Mac	e Ave	Baltimore MD	
P E E E		that (1)	Connelly Funeral Home of Essex 21;						
		23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not ent	er the mode of dyir	ng, such as cardia	ic or respiratory ar	rest,	Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	my	DCARDI	AL IN	FARCTI	ON	Onset and Death	
/Medical Examiner		resulting in death)  Due to (or as a consequ	ence of):						
	er.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequ	ence of):						
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Physician: The la	Be	25. Was case referred to medical examiner?  Hospital:		oth Oth	or.	eath (Check only o			
Physer this eral di	2	27. Manner of Death 28a. Date of Injury	R/Outpatier 28b. Time o	IL 3 DOA	4 □ Nursing	Home 5 Resid	dence 6 LIOthenow injury occurr		
ndlng tth. r: Afte e fune	atior	√Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury		rk?  Yes 2∐No				
r Atte er des recto by th	tifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At hot building, etc. (Specify	me, farm, str	reet, factory, office		28f. Location (S		er or Rural Route Number,	
led in safety of the led in the l									
29a. Certifier  (Check only (C								and due to the cause(s)	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Mentitier)							d (Month, Day, Year)		
and manner stated.  29c. License number  29d. Date signer  29d. Da							3/08		
6		30. Name and address of person who completed cause of death (Item	23a) (Type,	Print)		Α.	1	1.	
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Sta Registr	te ar	AUG 2 6 2008	K B	rech					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 20 Pay 2008 ear 11:10 А.м Evan Hurlev Marc 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Timonium Stella Maris Hospice 8. Date of Birth (Month, Day, ) cober 15, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Min. (Month October Months Days Hours M 2□ F 212-90-4360 45 1962 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2X No Maryland **Baltimore** Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 12214 Dover Road 21136 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Industry Chef 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Michael Hurley Jean Ann Schuler 19a. Informant's Name/Relationship (Type. Print) (Brother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Michael Hurley 2101 Boog Road, Hampstead, Maryland 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 08/22/08 Glen Burnie, MD 21061 22. Name and Address of FacilityLoring Byers Funeral Directors, Inc. 8728 Liberty Road, Randallstown, MD. 21133-4784 21. Signature of Funeral Service Licenses OUMOR MOUSS 23a. Part 1. Enter the clise see shock, or heart illure. I or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death List only one cause on each line Immediate Cause (Final disease or condition resulting in death) RECTAL CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2X No 1 □Yes 2 No 26. Place of Death (Check only one) Hospital: Other: ${}_{4} \square$ Nursing Home ${}_{5} \square$ Residence ${}_{6} \mathbf{X}$ Other (Specify) **HOSPICE** 1 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner and A burial-tran Physician/Medical the

Examiner

Completed by

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Certification: To

Medical

**Physician** 

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural"

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Important: If any Injury or once.

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Pages 1 and 2

21215-0036

Baltimore, Maryland

2008

Director

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/Medical

The law requires that the death certificate be executed physician as use for detached þ s been signed b should be deta After this certificate has page 2 Physician: director. funeral or Attending

ours after death.

neral Director: A
filled in by the fu death.

within 24 hours a

completely

ıD

State Registrar

P.O. Box 68760.

Records,

of Vital

25. Was case referred to medical examiner? 1 ☐ Yes 2 😿 No 27 Manner of Death

5 Pending investigation

determined

28a. Date of Injury (Month, Day, Year) 6 ☐ Could not be

28b. Time of Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 No

TIMONIUM, MD 21093

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 X Natural
2 Accident

3 ☐ Suicide

4 Homicide

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOOD

2300 DULANEY VALLEY RD. 32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month DOMACO HILBERT 7202U 3008 CEE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death IBOHURA MHA BALTIMAE WASHINGTON MEDICAL CENTER GLEH BURHIE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 X M 2 □ F 219-28-0648 June 3, 1933 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland N/A Y⊠Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3449 Chestnut Avenue 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Klyes 2 □ No If Yes, Give Korea Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 █ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Armco Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Glen Hilbert Bessie Maubray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Wolf Daughter 7357 Ridgewater Ct. Apt 202 Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XD Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cemetery 8/26/2008 Woodlawn, Maryland 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland 21. Signature f Funeral Service Licensee 23a. Part 1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, by heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aluomusus yoitasig24 disease or condition resulting in death) 2049 Due to (or as a consequence of): STROKE 3 HONTHS Sequentially list conditions, if any, and a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CONCESTIVE WEART FAILURE 1 ☐ Yes 2 ☐ No 3 ♣ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ►No 24a. Was an autopsy performed? Yes 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

law requires that the death certificate be executed physician and s the burial-tran Box 68760 attending p for use as o the signed by t I be detach ۵. of Vital Records, should b has page 2 The certificate l or Attending Physician: director, After this

Physician/Medical Medical Certification: To funeral filled in by the

Completed by

Be

3 ☐ Suicide

4 Homicide

(Check only one)

29b. Signature and title of certifier

**Physician** 

**Examiner** 

**Funeral** 

**Director** 

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Medical Examination in the Institute and Injury or other traumatic event, the "Medical Examination in the Institute and Injury or other traumatic event, the "Medical Examination in the Institute and Injury or other traumatic event, the "Medical Examination in the Institute and Injury or other traumatic event, the "Medical Examination in the Injury or other traumatic event, the Institute and Injury or other traumatic event, the Injury or other traumatic event or other event event or other event even

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

Be

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Examiner

Division 24 hours after deat Funeral Director; Hospital completely within 2. 1041

death.

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Duissonmoles Gióngres, 40

and manner stated.

29c. License number 11F5000

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) BOECEL 3575008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

CUICLERMO JOSE GIANCRECO 301 HOSPITAL DRIVE SELEN BURNIE, MD 20161

31. Date filed (Month, Day, Year) 32. Registrar's Signature

AUG 2 6

determined

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** August 21, 5:24 A<sup>M</sup> Ernest A. Hyson, Jr. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Anne Arundel Glen Burnie 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 X M 2 □ F 217-52-2714 Nov. 20, 1948 Maryland Director Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "had cal Examiner must be notified at Director 1 ☐ Yes 2 XNo MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 136 Glen Road 21060 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 1 ☐ Never Married 2X Married 1968 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced 1970 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Cooling System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe ( Ernest A. Hyson ပ Blanche Wroten 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Important: If item 27 any Injury or other troonce. Judy Hyson - wife 136 Glen Road, Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages ' ō 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Glen Haven Mem. Park 23, 2008 Glen Burnie, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signatura of Funeral Service Licensee M0005 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician metastatie nonsmall cell lunicance 2 years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month signed by the a 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by Prlmonary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☑ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deat To the Funeral Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 022782 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 West Delveder Avery, Baltmur, Muyland 21215 Berkman mo 31. Date filed (Month, Day, Year)
AUG 2 6 2008 2. Registrar's Signature Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 44 Harvey Eugene 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Parkville Genesis Elder Care If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Days Hours 216-68-8448 21 55 MD 53 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 X No Parkville Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 U.S.A. 8720 Emge Road 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Reisterstown Plaza Janitor N/A N/A 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2111 North Rolling Road, Baltimore, Marie Alexander-Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Arbutus Memorial 8/22/08 Arbutus, Md 22. Name and Address March F/H 21. Signature of Funeral Service Licensee West 21215 Baltimore, 4300 Wabash Ave, 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions.

**Physician** /Medical **Examiner** 

Physician

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

Be P

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 29a or 28a-f show yor jujury or other traumatic event, the Medical Examiner must be notified at once.

in by the funeral

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

To the Hospital or Attendiwithin 24 hours after death.
To the Funeral Director: A completely filled

Division or Vital Records, P.O. Box 68760,

Physician/Medical Exami Completed Medical Certification:

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of d.	V			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	al death 3 ☐ Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	cause given in Part I.		co use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
				24a. Was an autopsy performed	
25. Was case referred to medical			26. Place of De	eath Check onl one	
examiner? 1 ☐ Yes 2 1 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	OOA Other: 4 Nursing	Home 5 Residence	e 6 ⊟Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how i	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fact fy)	ory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
29a. Certifier 1 CertifyIng Ph (Check only one) 2 Medical Exar	yslcian: To the best of my known inter: On the basis of examination and manner stated.	owledge, death occurr ation and/or investigat	ed at the time, date and place on, in my opinion, death occ	ce, and due to the caus curred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
29b. Signature and title of certifier	0 0/	2	29c. License number	29d.	Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) AUG 2 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 08 2008 Day **Physician** 22 9:12 A<sup>M</sup> MICHAEL **JACKSON JOSEPH** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burnie Anne Arundel 914 Pine Road 8. Date of Birth (Month, Day, 06/03/ If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 № M 2 🗆 F 62 Maryland 212-44-1622 **Director** Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County show d other than "natural", or items 23a or 28a-f sho event, the Medical Examinal must be notified at 1 ☐ Yes 2 No Directo MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with U.S.A. 21060 7822 Solley Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 ☑No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Mechanic 11 Health and Mental Hygir tem 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) f item 27 is marked r other traumatic e Lulu Margaret Davis Werner Joseph Jackson, Sr. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 914 Pine Road, Glen Burnie, MD 21060 Barbara Harrell/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition ō Department of Important: If it any Injury or conce. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 08/27/08 | Glen Burnie, MD Glen Haven Mem Pk 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility G.J.Gonce Funeral Home, 21. Signature of Funeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical ue to ( as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Closease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the 1 ☐Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2.2 No 1 □Yes r this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Sister Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident i Director: d in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide an 24 hours.
the Funeral Directory filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical To the Hosp within 24 ho To the Fune completely f

DHMH 17 Rev 1/2001

State

Registrar

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 2

Dr. Mohan Suntharalingam, MD, 22 South Green St., Baltimore, MD 21201

29c. License number

047618

29d. Date signed (Month, Day, Year)

and manner stated

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kiuna Chimere Jackson 08-06249 Pleas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 27362

UNK UNK			of Marylar				nd Mental H	łygiene	200	10 2130
	R	For State gistrar		Cert	ificate of	Death		Re 2. Date of Deat	g. No.	3. Time of Death
Physician/ Medical Examine	r	Decedent's Name (First, Middle, La	imere		ckso	<u> </u>		Month August 15	Day Year 2008	0710 hrs
,	4	a. Facility Name (if not institution, gi 3700 Harford Road	ve street and num	nber)	4	b. City, Town, o Baltimore	r Location of Dea City	10,3400	4c. County of Deat	
Funeral		Social Security Number 6. S	Sex 7	7. Age (In yrs. la	st birthday)	If Under 1 Ye		in.	h (MM/DD/YYYY) 9. Bi Forei	gn .
Director		220-21-4806 1	M 2 F	19	Yrs.	Worldis	ys 1100/3 III	1.24	0.1989   0	ountry) MI
4 due	_	sual Residence of Decedent  0a. State 10b. County		10c. City,	Town or Location	on				10d. Inside City Limits
<u>*</u>	5	M		B	altimo					1 res 2 No
Maryland researt shore		0e. Street and Number		Α.		10f. Zip Code	(1)	11	Og. Citizen of What Co	untry?
filed within 72 hours after death with the Maryland Hygiene. Hygiene, do their than "natural", or items 23a or 28a-f show it, the Medical Examiner must be notified at once.		1308 Windry  1. Marital Status		edent Ever in U.S	5. 13. Was	Decedent of F	lispanic Origin? (	Specify Yes or No		erican Indian, Black,
or items 23	<u>.</u>	Mever Married 2 Marrie	1 Yes	2 UNO	1		an, Mexican, Puer	to Rican, etc.)	White, etc.	NOV
	- 1	Widowed 4 Divorce  15. Decedent's Education (Specify	or Dates:			Yes 2	specify: eation (Give kind o	of work done	Specify: 16b. Kind of Business	Jac L
2 hount "natu		Elementary/Secondary (0-12)	College (1-		during me	ost of working li	fe. DO NOT use r	etired)	0 1-	0. 5
5-0036 sed within 7 Hygiene. I other than the Medica	Completed			ear	(	Lash		me (First, Middle,	Sams Maiden Surname)	Club
nore, MD 21215-0036 sges I and 2 should be filed within 72 hours after not of Health and Mental Hygiens. It: If lieu 27 is marked other than "natural", other traumatic event, the Medical Examiner. To Be Commissed by 1	200	7. Father's Name (First, Middle, La	c V a A C				T N	me (First, Middle,	Simmon	15
2121sould be filtered by Mental 1 is marked tic event,		ga. Informant's Name/Relationship			19b. Mailing				nber, City or Town, Sta	te, Zip Code)
e, MD 1 and 2 sho Health and item 27 is	Ļ	Marie 5 m	mons	20b. F	1951 Place of Dispos		cemetery,	Date Date	20c. Location - City	or Town, State
altimore, mit. Pages I a spartment of He portant: If ite		1 Usurial 2 Cremation		om State	crematory or oth	ner place)	2 8	3.23.200	Baltin	pre, MD
Baltim permit. Pag Department Important injury or o	-	4 Donation 5 Other Spec 21. Signature of Funeral Service Lig			22. N	lame and Addre	ess of Facility	wann C.	Greene Fun	eral services
W S D E	_	23a. Part I. Enter the disease, or co	1. They	mo	140	105 Yo	ck and s	3altimo	e. Mil 21	Approximate interval
Physician 'Medical	-1	failure. List only one cause on	each line. a. Strangulatio		. Do not enter a	io mode or cy.	.g, 5557, 65 54-51			Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)		consequence of	f):					
	- -	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	consequence o	f):					
		cause. Enter Underlying Cause (Disease or injury that initialed	Due to (or as a	consequence e	ft:	_				
		events resulting in death) Last	d							
0, the executed serician and found transitions.	edical	UNPENDED	AMENDED						23d. Date of deliv	1001
876( tiffcate ng phy: as the b		F FEMALE: 3b. Was decedent pregnant in the past 12 months?	23c. If yes,	outcome of preg pirth		etal death	3 Ectopic pre	gnancy	Month	Day Year
Box 6876 c death certificate the attending phy ed for use as the 1	Physician/M	1 Yes 2 No 9 V Unknown	7 0	nant at time of de own	eath 5 O	ther (Specify)			2.10	
O. B hat the da		Part II. Other significant condition			esulting in the	underlying caus	se given in Part I.			to the cause of death?
S, P. Dines that it signed dobe de	ad by							1Y	es 2 No 3 F	Probably 4 Unknown autopsy findings available
ord: aw req nas beer 2 shoul	Completed					-		auto	opsy prior death	to completion of cause of
Rec The liftcate		25. Was case referred to medical				26.PI	ace of Death (Che	h-mark	2 No 1 🗸	Yes 2 No
/ital	m	examiner?  1 V Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatien		104	ırsing Home 5	Residence 6 🗸 O	ther: Scene
Division of Vital Records, P. nal or Attending Physician: The law requires the safter death.  The Invector: After this certificate has been signed in by the funeral director, page 2 should be director.	일	27. Manner of Death	28a. Date	of Injury Day,Year)	28b. Time of FOUND:		njury at Work? Yes 2 ✔ No	28d. Describe Subject as	how injury occurred phyxiated by stra	ngulation
Sion Attend death. ector:	<u>≅</u>	Natural 5 Pendin Investig	g nation Aug 15,		0700 hrs			28f. Location	(Street and Number or	Rural Route Number, City
Division Hospital or Attend 24 hours after death. Funcral Director:	Certification:	3 Suicide 6 Could a determination	not be	Stream				or Town, 3700 Harfor	State) d Road, Baltimore, I	∕ld.
		29a. Certifier 1 Certifying Phy	sician: To the be	st of my knowled	dge, death occu	urred at the time	e, date and place, nion, death occurr	and due to the ca	use(s) and manner as s e and place, and due t	stated. o the cause(s)
To the within To the comple	Medical	29b. Signature and title of certifier	and manner s	stated.			ense number		29d. Date signed	
		· Don my	O.C.M.E. August 15, 2008							
n <sub>2</sub>	}	30. Name and address of person w			m 23a)	1 D#n=01	eet, Baltimore	MD 21201		
		Donna M. Vincenti, MD		Medical Exa	6 N 25 25	Stre	et, dalumore			
Sta Registr	_	31. Date filed (Month) Day, Year o	4		_	_				

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person w

Stephen
31. Date filed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1500193280

Wilkers Arc. Ballo MD 21229

Robert Lee Jenkins Baltimore, Maryland 21215-0036 Known as

Division of Vital Records, P.O. Box 68760,

		For State of Registrar	Maryland		rtment of F tificate of I		Mental Hy	giene 2	800	27364
Physici	an	1. Decedent's Name (First, Middle, Last) Robert Lee Jenkins					2. Date of De		Vear	3. Time of Death
/Medic	cal						August	19 2	2008	1635 PM
Examir	er	4a. Facility Name (If not institution, give street and num	0 11	ore	4b. City, Town, or	more C	tu	V/A	ty of Death	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bi (Month, D	rth av, Year)	9. Birthp	lace (State or Foreign
Director		Usual Residence of Decedent	63	Yrs.		7.00.0	June 3	, 1945	Mary	
ryland how	_	10a. State 10b. County	10c. City,	Town or Loc	cation				10	Od. Inside City Limits
he Ma	Director	Maryland N/A		Baltir	nore					1 XYes 2 No
with the	Ē	10e. Street and Number 2156 Druid Park Drive		10g. Citizen of USA	What Coun	try?				
death	Funeral		dent Ever in U.S.	13. V	Vas Decedent of H	211 ispanic Origin? (S	pecify Yes or No	o- 14. Ra	ace - Americ	
filed within 72 hours after death with the Maryland Hygiene. Hygiene, the Han "natural", or items 23a or 28a-f show ent, the Ancical Examine coust to neithed at	by Fu	1 ☐ Never Married 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	2 <b>½</b> ] No e		Yes, specify Cuba  ☐Yes ②  ☐Yes	Specify:	o Hican, etc.)	Speci	ack, White, e ify: <b>W</b>	nite
2 hour	ted	15. Decedent's Education		16a. Deced	ent's Usual Occupa	ation		16b. Kind of E	3usiness/Inc	lustry
ithin 7 ne. han "r	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-	4or 5+)	life. D	kind of work done o	luring most of wor )	king	G: +	- C D- 1	
filed w Hygie other ti		17. Father's Name (First, Middle, Last)		Sup	pervisor	18. Mother's Nar	ne (First, Middle			ltimore
uld be Mental rked c	To Be	George Jenkins					nce McD		,,,,	
2 shour and h		19a. Informant's Name/Relationship (Type. Print) Saundra Jenkins Wife			g Address (Street a					
1 and Health tem 27		20a. Method of Disposition	20h Plac		Druid P		e, Balt	1more, 1		
Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from S	tate Atla	netery, crem antic	sition (Name of eatory or other place Cremator				,	Maryland
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, In. In once.		21. Signature of Funeral Service Liberate	211	)   <sup>22</sup> .	Name and Addres	s of Facility nss-Seit	z Funer	al Home	Tnc	-
		23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death.		JOSI TALL	s noau,	Dat CIIIO	re, mar	yland	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	05/5						7	Onset and Death
/Medical Examiner		resulting in death)  Due to (o	r s a consequer	nce of):						
Till (	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	r as a consequer	nce of):						
and transit	Examiner	that initiated events								
ficate be executed physician and street burial-transit		Due to (o	r as a consequer	nce of):						
tificate ig physas the	ledical	d								
ding Physician: The law requires that the death certified.  After this certificate has been signed by the attending t funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  23c. If yes, outc	ome of pregnanc	eath 3	Ectopic pregnancy				ate of delive	
the deay the a	ysici	1 ☐ Yes 2 ☐ No 4 ☐ Pregna 9 ☐ Unknown 9 ☐ Unknown	ant at time of dea		Other (specify)			N	lonth	Day Year
s that	by Ph	Part II. Other significant conditions contributing to dea	ath but not resultin	ng in the un	derlying cause give	n in Part I.	23e. Did	obacco use cor	ntribute to th	e cause of death?
equire een sig	ted k	Clrrhosis, renal ta	Mure				1 🗆	Yes 2 □ No	3☐ Prob	ably 4 Unknown
e law i has b	Completed						24a. Was	psy	prior to cor	osy findings available npletion of cause of
an: Th tifficate or, pag		25. Was case referred to medical					1 □Yes	2 No	death? 1 □ Yes	2 No
nysicia nis cer direct	To Be	examiner?	patient 2 EP		3 □ DOA Othe	26. Place of Dea	ome 5 ☐ Resi		her (Specifi	d)
ing PI	[:uo	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month	f Injury 28 , Day, Year)	Bb. Time of Injury	28c. Injury Work	at		how injury occu		/ <u> </u>
Attend death ctor: / y the f	ficati	2 Accident investigation 3 Suicide 6 Could not be	of Injury - At home	a farm etre		∕es 2 □No	28f Location (	Street and Norm	har or Oren	Route Number,
tal or / s after al Dire ed in b	Certification:	4 Homicide determined building	of Injury - At home g, etc. (Specify)	5, 101111, 0010	or, ractory, office		City or To	wn, State)	ber or nura	noute Number,
To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the base and manner and manner.	sis of examination	edge, death n and/or inv	occurred at the timestigation, in my op	ne, date and place pinion, death occu	e, and due to the rred at the time,	cause(s) and n date and place	nanner as st , and due to	ated. the cause(s)
To the confidence of the confi	Ž	29b. Signature and little of certifier	4		29c. License			29d. Date sign		
	-		MO			21113		AUG	UST	9005, 91
り		30. Name and address of person who completed cause GENUC		,	rint) NM He	AT) 920	107	BMIT	140	RE
Stat Registra	~	31. Date filed (Month, Day, Year)	gistrar's Signature	e .	ۯ n				, , , ,	
negistra	"	AUG 2 6 2008	1 J.J.	6284						

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			For		aryland / Dep			-	iene	
			1 - State Registrar		Ce	rtificate of D	eath	Re	9. No UU	8 27365
	Physici	ian	Decedent's Name (First, Middle, I	,				Date of Deat Month	Day Y	3. Time of Death
	/Medi	cal	4a. Facility Name (If not institution, g			45 City Town and	acation of Dooth	AUG	19 200	
	Examir	ner .	Genesis Elder			4b. City, Town, or L	ion		4c. County of	ltimore
	Funeral				ge (In yrs. last birthday,	If Under 1 Year	if Under 24 Hrs.	8. Date of Birth	- DQ	Birthplace (State or Foreign Country)
	Director		215-28-0158 Usual Residence of Decedent	1□M 2 <b>X</b> F	84 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 12 18	24	WV
	trylan show	_	10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits
	8a-f s	octo	MD NA		Balt:					1 XYes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itams 23a or 28a-1 show may injury or other traumatic event, the Medicul Event are marked rediffed at once.	Funeral Director	10e. Street and Number 1314 North Bel	ntalou St	reet	10f. Zip Code 212	216	10	0g. Citizen of Wh U • S	·
	death ms 2;	nera	11. Marital Status	12. Was Decedent		Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spe	cify Yes or No-		American Indian,
9	or its		1 Never Married 2 Married	Armed Forces?  1 Yes 2 X  1 Yes, Give	No	_	Specify:	Hican, etc.)	Specify:	White, etc. Black
21215-0036	ural',	Completed by	3 Widowed 4 □ Divorced	Year or Dates:						
7	"nat	iete	15. Decedent's (Specify only highest of	grade completed)	(Give	dent's Usual Occupation wind of work done dur DO NOT use retired)	on ring most of workir	ng F	16b. Kind of Busi Baltimo	ness/industry re City
12	filed withl Hygiene. Ither than	m o	12th grade	Coilege (1-4or:	5+)	Teacher			School	-
	be filed ital Hyg of othe event,	BeC	17. Father's Name (First, Middle, La				8. Mother's Name			
ylar	should be nd Mental marked o	ToE	James Swope			M	lary Bov	wles		
Maryland	12 sho h and I 7 is ma		19a. Informant's Name/Relationship			ng Address (Street and B Hershol				
	1 and 2 Health em 27 ther tra		Noreen E Warr	en-Daugne						ity or Town, State
Baltimore,	Pages nent of I ant: If its ury or of		1 ₩ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec			osition (Name of matory or other place)	I			
	permit. Page Department of Important: if any injury or once.		21. Signature of Fundral Service Lic			Memorial Name and Address		706 F	rbutus	, Ma
ä	Depa Impo any is		Vimitte	K. Smes	1000	archardyns 300 Wabas		Baltim	ore. M	d 21215
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused						Approximate Interval Between
	Physician	4 0	Immediate Cause (Final disease or condition	0 - /	CONDR	4 ART		15EA		Onset and Death
	/Medical Examiner		resulting in death)	u	a consequence of):	1 110.	0 10 7 0	15000	3 0	4.60
	Examine	L	Sequentially list conditions,	b. REN	SALF	AILUG	ZE			montos
Г	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		a consequence of).	2				
v	al-tra	xar	that initiated events resulting in death) Last	Due to (or as	a consequence of):	A				months
760,	icate be executed physician and s the burial-transit	cail		o ho li	JZ MON	ARY EI	nBOZ	1511		monetr
89	death certificate b attending physic d for use as the b		IS SERVICE					710		
Вох	ath ce ttendii	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1⊟Live birth		□Ectopic pregnancy			23d. Date	
	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	1 Yes 2 No	4∏Pregnant ai 9⊟ Unknown	t time of death 5	Other (specify)			Month	n Day Year
P.O.	that the ed by detac		Part II. Other significant conditions	contributing to death b	out not resulting in the u	nderlying cause given	in Part I.	23e. Did tob	acco use contrib	ute to the cause of death?
rds	quires n sign	d by	DIABE	PES M	ELLITU			1 ☐ Ye	s 2 □ No 3	Probably 4 Unknown
000	aw rec s bee	ojete	lyo PN	EVMON	e, A			24a. Was ar		ere autopsy findings available
of Vital Records,	The law	Completed						autopsy perform 1 Yes 2	red? dea	or to completion of cause of ath? ]Yes 2 ☐ No
/ita	Physician: Th this certificate ral director, pag	Bec	25. Was case referred to medical examiner?			2	6. Place of Death			2100
∑ \	S =	2	1 ☐ Yes 2 ☐ No		ent 2 ER/Outpatie	nt 3 DOA Other	₩Wursing Hon	ne 5 Reside	nce 6 Other	(Specify)
no	ding Phy th. After thi funeral o	ion:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time o Injury	Work?		l8d. Describe ho	w injury occurred	
Division	l or Attendi after death. Director: A I in by the fu	ficat	2 Accident investigat 3 Suicide 6 Could not	be og Dlag of lai	ury - At home, farm, st		s 2 No	28f. Location (Str	eet and Number	or Rural Route Number,
Θ	after after Dire d in b	Certification;	4 Homicide determine	building, et	c. (Specify)	cot, ractory, office		City or Town		or right riodig reambor,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edicai C	29a. Certifier (Check only one) Certifying I	Physician: To the best aminer: On the basis o	t examination and/or in	h occurred at the time, vestigation, in my opin	date and place, a	and due to the ca	use(s) and mann ite and place, and	ner as stated.  d due to the cause(s)
	o the	Mec	29b. Signature and title of certifier	and manner st		29c. License n	number	29	d. Date signed (	Month, Day, Year)
	r s ⊨ ō		8	any or	D	000	53150			
	/		30. Name and address of person wh		leath (Item 23a) (Type,				1000	192008
	5				fuple	9650 Se	nhyp	na s	cute	110
Te	Sta Registr		31. Date filed (Month, Day, Year)  AUG 2 6 20	- F7 - L	ar's Signature	all s		COIV	mble	40 4043

DHMH 17 Rev 1/2001

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			1 - For State Registrar	State of Mai	-		nent of H		nd Me		ene <sub>2</sub>	008	2736	6
B	Physici	an	Decedent's Name (First, Middle, Las.	,					1	2. Date of Death Month	Day	Year	3. Time of Deat	h
4	/Medic	cal	Harry Edgar Kirch			1				08-20-			1:15 P	М
	Examir	ier	4a. Facility Name (If not institution, give Genesis Brightwoo				City, Town, or Luther		Death			unty of Deat		
3	Funeral		5. Social Security Number 6. Se		(In yrs. last birti	hday) If L	Jnder 1 Year	If Under 2	4 Hrs. 8	B. Date of Birth (Month, Day,		9. Birt	hplace (State or Fore	aign
Ь	Director		217-12-0231	<b>⊉</b> M 2□F	84 Y	rs. Mo	nths Days	Hours	Min.	07-22-1	924	Co	uintry) WV	
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location	n						10d. Inside City Lim	nite
	Maryli f •ho	ō					•						1 □ Yes 2 <b>X</b> □	
	28a-	rect	MD Harf	ora	вет	Air	of. Zip Code			10	g. Citizen	of What Co	untry?	
	hours after death with the Maryland tural', or Items 23e or 28e-f ehow at Exendinar puel be notified at	Funeral Director	608 L. Churchill	Rd			2101	4			US	Α		
	ems	Iner	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was I			in? (Spec	rfy Yes or No- ican, etc.)	14.	Race - Ame Black, White		
36	or It	by Fu	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No If Yes, Give		1	es 2X No			,		ecity: Wh		
21215-0036	d within 72 hours after death with the Marylan Itene. r than "natural", or Items 23e or 28e-1 ehow the Modical Examinat roughts natified at	d ba	15. Decedent's Edu	Year or Dates:	162	Decedent's	Usual Occupa	ation			Sh Kind	of Business/	lodustry	
15	in 72 n "nat	Completed	(Specify only highest grad	le completed)		(Give kind )	of work done of OT use retired	durina most (	of working		OD. KING	Di Dusiriessa	industry	
212	e filed within Il Hygiene. other then "	mo;	12	2 College (1-4or 5+)		le Sp	licer	Tech			Tele	phone	Co	
nd	be filed ital Hyg id othe event,	Be	17. Father's Name (First, Middle, Last)					18. Mother	's Name (	First, Middle, M	aiden Sui	mame)		
yla		2	George Kirchner							Smith				
Maryland	C1 40 - 68		19a. Informant's Name/Relationship (T) Bruce A. Kirchner							Route Number, ttsvill	-			
ē,	1 and Health tem 27 other tr		20a. Method of Disposition	(5011)	20b. Place of	Disposition	(Name of	l.	Da	-		ion - City or		
Baltimore,	0 0		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,				y or other plac	· 1	າຍ_າາ	-2008				
altir	그는 근 중		21. Signature of Funeral Service Lights		Bayvie								ne of BelA	lir
ä	Depermine Permine Perm	( d)	Diane	nacla						. Rd Bel				XII
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the	ne death. Do n	ot enter the	mode of dyin	g, such as c	ardiac or	respiratory arre	st,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	(erebr	していると	were	a	cider	N				Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a				entr		٥				
¥		-	Sequentially list conditions, if any, leading to immediate	b. Chronic Due to (or as a		mu	rvc	trim	nuna	m g	-nec	40		
	ansit A	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1.	Jensi	,								
ó	be executed icien and burial-transit	Еха	resulting in death) Last	Due to (or as a	consequence o	f):								
8760,	icate be executed physicien and stransit	cal	(	a Ari	a) 1	Fibri	Mah	^						
9	The law requires that the death certificate ate has been signed by the ettending phys page 2 should be detached for use as the	Physician/Med	IF FEMALE:											
Вох	leath certific ettending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Fetal death		pic pregnancy				23d	. Date of del Month	very Day Year	
P.0.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tir 9□Unknown	ne or death	5 LI Othe	er (specify)		-					
	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions co	ntributing to death but	not resulting in	the underly	ring cause give	en in Part I.		23e. Did toba	acco use	contribute to	the cause of death?	7
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Š	al or / a after I Dire	ert	4 Homicide	building, etc.	(Specify)		201019, 011100			City or Town,	State)			
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of	my knowledge,	death occu	urred at the tim	ne, date and	I place, an	d due to the car	use(s) and	d manner as	stated.	
	the H nin 24 the F the F	ledical		ner: On the basis of e and manner state	d.	vor investig	ation, in my of	pinion, death	occurred	d at the time, da	le and pla	ice, and due	to the cause(s)	
	with Con	Σ	29b. Signature and title of certifier	+ flor	rem	$\supset$	29c. License	number	D G	29	d. Date si	igned (Monti	n, Day, Year)	-
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	10		30. Name and address of person who co Jayant Hirrary	ma.	7505	USLE	ROR	(VE	0.0	2 000	T	MUSIN	v m	
	Sta	te	31. Date filed (Month, Rey, Year) 008	32. Registrar	s Sidnature	and I			71	11 30-1	, ,,	, _ ,	7	
	Registr		AUG & 0 2000	THE STATE OF	An Sel	No. of Concession, Name of Street, or other Persons, Name of Street, or ot								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, b. perINF .G886, 12/5/08 WS

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>008</u> **Physician** 24,  $A^{M}$ Joseph Ρ. Kagan August 5:10 /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death **Examiner** Brighton Gardens of Tuckerman Lane Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign Country) New York, NY 7. Age (In vrs. last birthday) **Funeral** 1**X** M 2□ F Months Days 96 578-36-4846 April 4, Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🖾 No Montgomery Maryland Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a other traumatic event, the "Actical Even in a state other traumatic event, the "Actical Even in a state of the state of t 5550 Tuckerman Lane 20852 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 ò 1∐Yes 2∏XNo Specify: Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Civil Service U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Kagan ဂ္ Lena Megezis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nephew 106 Promenade Lane Eric Kagan B Williamsville, NY 14221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or c 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 6 ☐ Other (Specify) Mt. Ararat Cemetery 8/28/08 Farmingdale, NY 21. Signature of Funeral Service Licen 22. Name and Address of Facility
Star of David Chapels Lannes 1236 Wellwood Ave., W. Babylon, NY 11704 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Immediate Cause (Final disease or condition resulting in death) then Scle **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed pertention. and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autonsy certificate 1 □ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🔀 No Other: 4 M Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

© Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely (Check only one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 13 KEIMY pmoc sory MO 6320

State

Registrar

31. Date filed (Month)

AUG 2 6

2008

gistrar's Signature

Donald Keefer

**Physician** /Medical

**Examiner** 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has hean simpled by the control of the Funeral Director.

Division of Vital Records, P.O. Box 68760.

Examine

Physician/Medical

Completed by

Be

Certification: To

Medical

White

20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Frieral Section (censee

Martin D. Lawson

20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory 8/25/2008

1608 Division Street, Lutherville, Maryland 21093 20c. Location - City or Town, State

Baltimore, Maryland

Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland

23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death dais

2:20 p.M

10d. Inside City Limits

1 □Yes 24Ho

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

(Son)

IF FEMALE: 23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 No

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

4 Pregnant at time of death

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

dementi vanced Myocardia

Hospital:

1 Tes 2 No 3 Probably 24a. Was an

1 ☐ Yes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

🗀 Unknown

25. Was case referred to medical examiner?
1 Ves 2 □ No

27. Manner of Death 1 Natural
2 Accident 5 Pending investigation

28a. Date of Injury (Month, Pay, Year) 20/08 6 ☐ Could not be

and manner stated.

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury. evening M

28c. Injury at Work? 1 □Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred penaled cown with tab charm, Poundant to rent to bed I conscious hip pair 28f. Location (Street and Number or Rural Floute Number City or Town, State)

29a Certifier (Check only one)

3 Suicide 4 ☐ Homicide

of Place of Injury - At home, farm, street, factory, office building, etc. (Specify). Tella Nans Hospice/Re Varis Hospice 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Dulaney Valley Rd/

29b. Signature and title of certifier

Lendall

Cusutzur

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

+avuaemD 31. Date filed (Month, Day, Year) AUG 2 6 2008

State Registrar

completely filled in by the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 4a. Facility Name (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11/15/1928 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days **XX**M 2 □ F 216-28-0209 79 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director 1 X Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō 23a 2105 Bank Street Funeral United States Pages 1 and 2 should be filed within 72 hours after death onent of Health and Mental Hygiene. 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 'natural", or Specify: White 1 ☐ Yes XXNo Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4 or 5+) other than 12 Shipping Clerk Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Walery Kalinski မ Anna Domzalski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau Melvin Kalinski - Son 812 S. Ellwood Avenue Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemeter), crematory, or other place)
Sacred Heart of Jesus 08/28/2008 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility David J. Weber Funeral Homes P.A. عذ 401 S. Chester Street Baltimore, Maryland 21231 Part : Enter the disease, or complications that cause of each line. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition FRREST **Physician** ARDIAC /Medical resulting in death) Examiner ORONARU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed bunal-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 🗆 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Linknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Yes 2 **N**0 2 No Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \( \sum \) Nursing Home 1  $\square$  Inpatient 5 ☐ Residence 6 ☐ Other (Specify) ၉ 2 KER/Outpatient 3 DOA this the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred al or Attending P. s after death. 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 - Homicide City or Town, State) n 24 hours a se Funeral D Medical 29a, Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (check only one) completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marrier stated. To the 1 within 2 To the 1 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1.6 Kichardson 600 North Wolfe St, Baltimore, MD, 21287 32. Registrar's Signature 31. Date filed (Month, Day, Year) State coste Registrar AUG 2 8 6

DHMH 17 Rev 1/2001

1 - For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

DHMH 17 Rev 1/2001

		for State Registrar	State o	of Maryl		artment of H			giene Reg. No.	2000	27	27
Physic	an	1. Decedent's Name (First, Middle	, Last)		1/2	HCHNEE		2. Date of Dea	ath	2008	3. Time of	Death
/Medi	cal	WALTER  4a. Facility Name (If not institution	, give street and nu	ımber)	K	4b. City, Town, or	Location of Death	L		2008 County of Death	8:53	Ам
		SUNRISE ASSISTE				PIKES		T		BALTIMO		
Funeral Director		5. Social Security Number 216-05-5595	6. Sex 1 ☑ M 2 ☐ F		yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month Da 09/19/	1914	9. Birth	olace (State ontry) MD	or Foreign
land ow		Usual Residence of Decedent  10a. State 10b. County		10c	. City, Town or Lo	ocation				1	I 0d. Inside Ci	ity Limits
e Mary Ba-f sh	ctor	MD BAL	TIMORE	ŀ		BALT	TIMORE					2 No
death with the Maryland ims 23a or 28a-f show r must be notified at	Dire	10e. Street and Number 3800 OLD COURT	ROAD, #11	4		10f. Zip Code 212	208		10g. Citiz	en of What Cour	ntry?	
	by Funeral Director	11. Marital Status  1 □ Never Married 2 🛣 Marri 3 □ Widowed 4 □ Divorced	12. Was Dec	edent Ever i orces? 2  No ive	1	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 No		pecify Yes or No Rican, etc.)		4. Race - Americ Black, White, Specify:		
within 72 hours after ene. than "natural", or ite	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	completed) College (	1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of work f)			d of Business/In		
filed w Hygie Sther ti		17. Father's Name (First, Middle, I		<del>)+</del>	CERIII	TED PUBLI	18. Mother's Nam			COUNTING Burname)	<u> </u>	
arylan should be i and Mental s marked o umatic eve	To Be	HARRY		K	USHNER		FANNI	E		ROSENS	TEIN	
and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationsh JEANETTE KUSHN		E		ng Address (Street					21208	3
Pages 1 nent of H nnt: If iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State		osition (Name of matory or other place HEBREW (	CEM. 08/2		REIS	eation - City or To	IN, MD	
Dealt.  permit. Departr Importa any inju		21. Signature of Funeral Service I	icensee			2. Name and Addres 8900 REIS				& BROS. ESVILLE	-	
Physician		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that conly one cause on control	caused the deach line.	death. Do not en						Approximat Interval Bet Onset and	te tween Death
/Medical		resulting in death)	aDue to	r as a cor	nsequence of):	ey dise					3 141	n He
	Examiner	Sequentially list conditions, if any healthy to financially list conditions, if any healthy list conditions are also conditions and healthy list conditions.									5 year	<u>/\$</u>
icate be executed physician and the burial-transit	dical	resulting in death) Last	Due to	(or as a cor	nsequence of):							
To the Hospita or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, ou 1 ☐ Live 4 ☐ Preg 9 ☐ Unki	birth 2 🗀 gnant at time	Fetal death 3	☐ Ectopic pregnanc☐ Other (specify) _	у		2	3d. Date of delive		Ye ar
ecords, F. law requires that as been signed b 2 should be deta	ģ	Part II. Other significant condition	ns contributing to d	leath but not	t resulting in the u	inderlying cause giv	en in Part I.		obacco us	se contribute to t		death? "Unknown
The law reate has been page 2 sho	Completed							24a. Was autor perfo		24b. Were auto prior to co death? 1 ∐Yes	opsy findings ompletion of a	available cause of
Sician: T certifical rector, pa	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 🖪 No	Hospital:			nt 3 DOA Oth	26. Place of Deal	th (Check only o	ne)	. <u>V</u>	ASSI	STED-
ng Physter this	on: To	27. Manner of Death	28a. Date		2 ER/Outpatie 28b. Time of Injury	0	v at	ome 5 ☐ Resi 28d. Describe		Other (Special occurred)	ify]L I I V I	NG
Attending ar death. ector After by the fune	icatio	2 Accident investig	jation			M 1□	Yes 2 □ No	29f Lagation (	Ctuant and	d Number or Rui	ral Plauta Nu	
talor A	Certification:	4 ☐ Homicide determ	ned build	ling, etc. (S)	pecify)	reet, factory, office		City or To		I Number of Fur	ai noute ivui	nber,
To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director After this completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifyin (Check only one)	ig Physician: To the Examiner: On the I and mar	e best of my basis of exa nner stated.	/ knowledge, dea mination and/or i	th occurred at the tinvestigation, in my o	me, date and place opinion, death occu	e, and due to the rred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(	s)
To the Complex	M	29b. Signature and title of certifier	06	m	7	29c. Licens				e signed (Month		
	1	30. Name and address of person	who completed cau	ise of death	(Item 23a) (Type.	Drim4)	426			Ust 21	100	8
6		Elliot Roths	child 4	1000 (	old con	rt Ad.	Pikesville	e, MD	212	208		
Sta Regist		31. Date filed (Month, Day, Year)  AUG 2 6 2	008	Registrar's S	Signature Soa	AP Y		,				
DHMH 17 Rev 1/2	2001	I I W W U L	AND SECTION		- Jugar							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - Registrar  Amend Item tate of Maryland Deposty 267 of dispath and Menta  Certificate of Death	I Hygiene Reg. No	<sup>e</sup> 2008 273 <b>7</b> 2
	Physicia		1. Decedent's Name (First, Middle, Last)  2. Date More (More Company)		Year 3. Time of Death 22:46 M
Mark of the second	/Medic Examin	er	4a. Facility Name (If not institution, give street and number)  Ame Andel Medical Certer Anepels Mo	e of Birth	c. County of Death Anne Arundel
	Funeral Director				r) Country) 1946 Maryland
	Maryland a-f show	ctor	10a. State 10b. County 10c. City, Town or Location  Maryland Anne Arundel Pasadena		10d. Inside City Limits 1 □ Yes 2 💆 No
	h with the	Dire		10g. C	Citizen of What Country?
5-0036	vithin 72 hours after death with the Maryland nne. than "natural", or items 23a or 28a-f show Medical Examiner must be notified at	by Funeral	If Yes, Give 1 ☐ Yes 2 No Specify:  Year or Dates:	s or No- etc.)	14. Race - American Indian, Black, White, etc.  Specify: white
N-6121	filed within 72 ho Hygiene. other than "natur: ent, me inedical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Truck Driver		Kind of Business/Industry
z pue	be od od ev	Be	17. Father's Name (First, Middle, Last)	Middle, Maide Schaff1	
Maryland	d 2 should be th and Menta 7 is marked traumatic ev	ဥ	19a. Informant's Name/Relationship (Type. Print)  19b. Malling Address (Street and Number or Rural Route)		
Baltimore, M	jes 1 and t of Health If item 27 or other to		Patricia A. Koontz (wife)  20a. Method of Disposition  1 M Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  Place of Disposition (Name of cemetery, crematory or other place)  Meadowridge Mem. Pk. 08/22/200	20c. I	Location - City or Town, State
Balt	permit. Pag Departmen Important: any Injury once.		21. Signature of Funeral Sarvice Licensee  22. Name and Address of Facility McCully-Polyniak Funer 3204 Mountain Road, Pa	al Hom	ne P.A. a. Marvland 21122
	Physician /Medical Examiner	er /	23a. P. C. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirators, or heart failure. List only one cause on each line.  Incrediate Cause (Final resease or condition a. Due to (or as a consequence of):		Approximate Interval Between Onset and Death
58760,	cate be executed physician and the burial-transit	edical Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Custo for all changes once off Custo (or as a consequence of):  Due to (or as a consequence of):		
O. Box (	ath certifi attending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 prioriths? 1		23d. Date of delivery Month Day Year
rds, P.	tuires that the de n signed by the a ld be detached f	by	Part II. Other significant continuous community is decar but no crossing in the circles ying states given in a		co use contribute to the cause of death?
al Records,		Completed		4a. Was an autopsy performed? □Yes 2	24b. Were autopsy findings available prior to completion of cause of death? No 1 □Yes 2 No
f Vit	Physiciar this certif al directol	lo Be			e 6  ☐ Other (Specify)
Division of Vital	ng Affer	Certification: To	27. Manner of Death    27. Manner of Death   28a. Ďate of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes 2   No   Yes 3   Yes 3   Yes 3   Yes 4   Yes 3   Yes 4   Yes 3   Yes 4   Yes 4	escribe how in	njury occurred  t and Number or Rural Route Number,
DΙΧ	tal or At is after of al Direct ed in by	Certifi	3 Suicide 4 Homlcide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	ity or Town, St	tate)
	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fi	Medical		the time, date a	and place, and due to the cause(s)
	Veith:	X	0 0 0 0		Date signed (Month, Day, Year)  08 / 18 / 2058
(	10)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AUG 2008  Registrar's Signature  AUG 2008	ARRIA	Polis, Med 2 140 1
	Sta Regist		at 31. Date filed (Month, Day, Year) 2008 Registrar's Signature AUG 2 6 2008		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 24a per verb., g882, U8/26/08dhb

Reg. No.

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Karppinen Marion /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Ellicott City Ellicott City Health & Rehab If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Days 1 □ M 2 🗓 F 383-40-3473 Apr 10, 1941 67 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a State 10b. County 28a-f show 1 ☐ Yes 2 ▼ No must be notified Ellicott City Director Howard 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number ō 21043 USA 3000 North Ridge Road 23a by Funeral 14. Race - American Indian, items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married ō 1 ☐ Yes 2 No Specify: Specify: white Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical unk unk th and Mental Hygiene.
7 is marked other than "traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) unk unk ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3000 North Ridge Road Ellicott City, MD Ellicott City Health & Rehab 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5⊠Other (Specify) in state Director 21. Signature | Funeral Struce Licentee Ronal of S • 130 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardio Vas Cular Immediate Cause (Final disease or condition resulting in death) Atherosclevolic Physician Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine I or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit 9 Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Other: 1 Yes 2 No 1 🔲 Inpatient Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 Naturai Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760. To the Hospital o within 24 hours aft To the Funeral Di completely filled in

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) +Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

Medical

29d. Date signed (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Month, Day, Year) AUG 2 6 2008

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 dd /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ER HOWK 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 🗓 🏋 2 🗆 F Yrs 61 Director 215-46-7257 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes X No MD Queen Anne's Chestertown Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. and the file and 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Examiner must be runy or other traumatic event, the Medical Examiner must be USA 21620 #6 312 Park Row Funeral Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2√√No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🏋 🗓 No Specify: White Specify. ģ 3 ☐ Widowed 4 💆 bivorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Transportation Truck Driver 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth May Monroe ၉ William Albert Kuhl Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4 Taney Ct, Taneytown, MD 21787 permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. Daughter Rebekah Deniece Kuhl 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Baltimore, MD Aug 26, 2008 Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of the rus ricel 22. Name and Address of Facility Fink Funeral Home, P.A. M01148 426 Crain Hwy S., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** TASTATIO Equentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and burial-trar Due to (or as a consequence of) physician Physician/Medical as the l attending properties of the pr IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe certificate 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA ၉ After this To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral of 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: il or Attending Patter death. (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

Registrar DHMH 17 Rev 1/2001

State

6 ☐ Could not be

AUG 2 6

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

CROSS ST.

32. Reistrar's Signature

3 ☐ Suicide

29a. Certifier

Medical

4 ☐ Homicide

29b. Signature and title of certifier

PAULR. JOHNSON

31. Date filed (Month, Day, Year)

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore.

requires that the death certificate be executed

Box 68760,

P.O.

Records,

Division or Vital

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

252487

CHOSTONTOUN MD 2/620

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

AUGUST ZZ, 2008

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20 2008 Month rigust 1.56A M **Physician** Karvar /Medical Examiner alstown Korthwest If Under 24 Hrs. 5. Social Security Numbe Age (In vrs. last birthday If Under 1 Year Date of Birth (Month, Day, **Funeral** Year) Months Days Hours 173-30-6074 24,1937 Director 70 Sept. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. There of Health and Mental Hygiene. The stress 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No MD Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 603 Pamela Road 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N.S.A. Police U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aaron Elvin Karvar Sr. Dorothy Jeffery 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. M. Eileen Karvar/ Wife 603 Pamela Road Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Aug. 2 2008 Department of Important: If it any Injury or conce, 1 XBurial 2 ☐ Cremation 3 ☐Removal from State Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vets. Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation Services 1 2nd Avenue SW Glen Burnie, MD 21061 MO1357 Varieur 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate 4 6 1 Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) bue to (or as a consequence of): **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24a. Was an autopsy performed?
1□ Yes 2☑ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has b irector, page 2 sl To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 24 hours after deaun.

• Funeral Director: After this or stately filled in by the funeral dir 1 ☐ Yes 1 Inpatient 2 EN/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ð LaMont C. Smith 5401 Old CourtRoad Randallstown MD 21133

Division or Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Register's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician anlssa (1)8 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner Greene St boutimor )mms 99 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Fo 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year Months Days Hours 1 □ M 2 🖬 F 54 DECEMBER 4, 1953 MARYLAND **Director** Usual Residence of Decedent alth and Mental Hygiene.

27 is marked other than "natural" or "traumatic event. Its and the second and managements are also as a second and an area of the second and area. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Yes 2 □ No Director MARYLAND BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number S. FAYETTE 2120 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 WNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: BLACK 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DWN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental WASHINGTON GEORGE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra once. LASHALON ROBERTS GAUGHTED 2003 PENKOSE AVE., BACTIMORE, MD 21223 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MT. ZION CEMETERY 108-28-2008 LANSDOWNE, MARYLAND 4 Donation 5 DOther (Specify) 22. Name and Address of Facility JCSEPH H. BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licensee lliams 2140 N. FULTON AVE., BALTIMORE, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Coronary Amery **Physician** roscurotic disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hypertension be executed the burial-tran physician Physician/Medical death certificate 33 asn IF FEMALE: 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Гo in the past 12 months? Month Day Year 5 Other (specify) P.O. | 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 Wnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an has page certificate 1 □Yes 2 □No of Vital or Attending Physician; Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death eral Director; After th filled in by the funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature

3

State Registrar 31. Date filed (Month, Day, Year)

AUG 2 6

Smedly 32 Manistra

32. Segistrar's Signature

who completed cause of death (Item 23a) (Type, Print)

MD

Snash )

Greene Street Baltmore, MD21201

08-06471 Christopher Khali	Hva	Please Type or Print in Black Inde	nent of Health and Mental Hygiene	
Christopher Khan	1-	- For State Certific	- t- of Dooth	Reg. No. 2008 2737
Physicia		egistrar  I. Decedent's Name (First, Middle,Last)	2. Date of De	path 3. Time of Death Day Year 0433 bro
Medical Examin		Christopher Khalil	Lynch Month August 2	24, 2008 0422 hrs
1	4	4a. Facility Name (if not institution, give street and number)	Baltimore City	4c. County of Death
		Sinai Hospital  5 Social Security Number   6 Sex   7 Age (In yrs. last b		Birth(MM/DD/YYYY) 9. Birthplace (State or
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b	Yrs. Months Days Hours Min.	Foreign
	٤	Usual Residence of Decedent	118. 11.3	
any		10a. State 10b. County 10c. City, Tow	wn or Location	10d. Inside City Limits 1
and show	5	MD	timore	10g. Citizen of What Country?
69.8 ne Maryland or 28a-f show	Director	10e. Street and Number	10f. Zip Code	Tog. Citizen of What Country:
death with the Maryland or items 23a or 28a-f sho		11 Marital Status 12 Was Deceden Ever In U.S.	A 2/239  13. Was Decedent of Hispanic Origin? (Specify Yes or	No- 14. Race - American Indian, Black,
tems st be	Funeral	Armed Forces?	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
ter de		3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:	Specify: DIOCIC
ours af atural	d b	15. Decedent's Education (Specify only highest grade completed) 16	ia. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
6 172 ha an "n	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	TNFaut	INFANT
5-0036 fled within 7 Hygiene. I other than	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middl	
215- be filed ntal Hyg rked of	Be C	Coron Harris	Tenesha	LUNCH
21 Me Me	TOE	19a. Illioniant's IV- Cittolationship (1)pol	19b. Mailing Address (Street and Number or Rural Route )	Numb ity or Town, State, Zip Code)
MD d 2 sho lth and n 27 is	1	Tenesha Lynch (Moller)	ce of Disposition (Name of cemeter) way Ap	+ A. Botto MD 21239
re, sland fHeal ffiten		1 Rurial 2 Cremation 3 Removal from State crer	matory or other place)	
Baltimore, permit, Pages I al Department of He Important: If ite		4 Donation 5 Other Specify:	lawn Cemetery 8/28/08	Baltimore, MD
Salt ermit. Departs mport njury		21. Signature of Funeral Service Licensee  Mo 140	Wang his city of	ineral services
Annual Control of the	-	236 Part I. Enter the disease, or complications that caused the death. Do	o not enter the mode of dying such as cardiac or respiratory	arrest, shock, or heart Approximate Interval Between Onset and
Physician Medical	-	/ / failure. List only one cause on each line.	ained death in infancy (SUD	Death
aminer		Immediate Cause (Final disease or condition resulting in death)  a. Sudden unex, 12  Due to (or as a consequence of):		
		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		
d d	Exan	events resulting in death) Last  Due to (or as a consequence of):		
executed an and al - transi	ical	MUNPENDED AMENDED 23a,27,28	8a-i, perME, G883 9/30/08 T	T
		IF FEMALE: 23c. If yes, outcome of pregnal	ncv	23d. Date of delivery
Box 68760, e death certificate be the attending physici ed for use as the buri	Physician/Med	23b. Was decedent pregnant in the	2 Fetal death 3 Ectopic pregnancy	Month Day Year
OX 6 ath ce attend attend	sici	1 Yes 2 No 9 Unknown 9 Unknown	n 5 Other (Specify)	-
Division of Vital Records, P.O. Box Hospital or Attending Physician: The law requires that the death Euneral Director: After this certificate has been signed by the atte tely filled in by the funeral director, page 2 should be detached for u	Phy	Part II. Other significant conditions contributing to death but not resu	ditting in the diderlying codes given in the city	oid tobacco use contribute to the cause of death?
P.O.	l by		1	Yes 2 No 3 Probably 4 Unknown
ds, require	Completed			Vas an 24b. Were autopsy findings available autopsy prior to completion of cause of
cor e law i e has t ge 2 sh	Пp			performed? death? /es 2 No 1 Yes 2 No
IRE		25. Was case referred to medical	26.Place of Death (Check only one)	
<b>/ita</b> ysicia his cer direct	o Be	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ E		
of Vital Records, ng Physician: The law requir After this certificate has been s neral director, page 2 should I	-	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	Look injury	ribe how injury occurred
ion ttendii leath.	atio	a la tala levestication	rna 3:13 apri — · · · — ·	
Division of Vital Rec To the Hospital or Attending Physician: The L within 24 hours after death. To the Funeral Director: After this certificate b completely filled in by the funeral director, page	Certification:	1 5 Suicide 6 Could not be 1 ho	ne, farm, street, factory, office building, etc.  28f. Locat or To	ion (Street and Number or Rural Route Number, City wn, State) 3623 Glengyle Ave 7 Baltimore, MD
Dospital hours meral y fille	S	4 Homicide	e, death occurred at the time, date and place, and due to the	
the Harmin 24 the Fr	Medical	one) 2 Medical Examiner: On the basis of examination and	d/or investigation, in my opinion, death occurred at the time,	date and place, and due to the cause(s)
To the within To the comple	Med	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		Land & muthall man	O.C.M.E.	August 24, 2008
		30. Name and address of person who completed cause of death (Item 2	23a)	
		Pamela E. Southall, MD Assistant Medical Exam	niner 111 Penn Street, Baltimore, MD 2120	11
	tate	71 11 9 6 7/11/12 7/20 a	e Boreli	
Regis	stra	AUG Z O ZUUO REGIME AG		

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Pleas	e Type or Pri					-	_	jible.	
		For	State of M	arylan	d / Depa	rtment of F	Health and N	Mental Hy	giene 2	306	27378
		1 - State Registrar			Cer	tificate of	Death		Reg. No.		
Physicia	an	1. Decedent's Name (First, Middle, I	Last)					2. Date of Dea	Day	Year	3. Time of Death
/Medic		Robert C. Lee  4a. Facility Name (If not institution, of	rive street and number			4h City Town o	r Location of Death	8-19-		ty of Death	7:00P M
Examin	er	Gilchrist Cer	·			Towson	Location of Death			Balto	
Funeral			. Sex 7. Ag	je (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th v. Year)	9. Birth	nplace (State or Foreign untry)
Director		216-30-7537 Usual Residence of Decedent	1 🕅 M 2 🗆 F	73	Yrs.	Worldie	Tiodis Iviii.	6-18-19	35		Md.
land ow		10a. State 10b. County		10c. City	, Town or Loc	cation					10d. Inside City Limits
Mary a-f sh ified	ctor	Md. Balto.		Es	sex						1 □Yes 2 □ No
ith the or 28; e not	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Cou	untry?
ath w s 23a nust b		33 Rockywood La				21221		USA			
ter de item	Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Married</li></ul>	12. Was Decedent Armed Forces? X Yes 2		5.   13. V	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Specify Yes or No- to Rican, etc.) 14. Race - Ame Black, Whit			
filed within 72 hours after death with the Maryland Hygiene. uther than "naturaly", or items 23a or 28a-f show ent, it o Modical Examiner must be notified at	by	3 ☐ Widowed 4 🔀 Divorced	If Yes, Give Year or Dates:		1	☐Yes <b>X</b> ☐No	Specify:		Spec	eify: Wh	ite
72 ho	Completed	15. Decedent's (Specify only highest of	Education grade completed)		16a. Deced	lent's Usual Occup	pation during most of work	tina	16b. Kind of	Business/Ir	ndustry
vithin ene. <b>than</b> "	mp	Elementary/Secondary (0-12)	College (1-4or	5+)			during most of work d)	3	0.165	. 1	
filed v Hygie other i	Be Co	12th 17. Father's Name (First, Middle, La	st)		Musi	cian_	18. Mother's Nam	e (First, Middle,	SelfEm		а
Aental Aental rked o	To B	Robert L. Lee					Loretta	a Gaff			
shou and N is ma		19a. Informant's Name/Relationship	, ,,				and Number or Rui				
and and tealth m 27		Colleen M. Find	DTR				Circle F				
ages 1 nt of P : If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3				sition (Name of natory or other plac		Date	20c. Location		own, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturaly", or items 23a or 28a-f show any injury or other traumatic event, it a Modical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Spe- 21. Signature of Funeral Service Lice			Bayvie	. Name and Addre	8-27-	-2008	Balto	•	
permi Depar Impo any ir		Bellevice of Pulleral Service Lice	11220					Schimune			
		23a. Part1. Enter the disease, or co	emplications that caused	the death			air Rd. N ng, such as cardiac			- 217	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	ly one cause on each	50 /	OGA:	real (	Ancel	R			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):	1					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Lxammer	ŗ.	Sequentially list conditions,	b Due to (or as	a consequ	ence of):						
d A	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		a consequ	01100 017.						
be executed cian and courial-transit		resulting in death) Last	Due to (or as	a consequ	ence of):		<del></del>				
eath certificate be er attending physician for use as the burial	Physician/Medical		d								
certific ding p	/Med	IF FEMALE:	23c. If yes, outcome	of pregnal	acv						
atten for u	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 4 Pregnant a	2 🗌 Fetal	death 3	Ectopic pregnanc Other (specify)	ey .			oate of deli Month	very Day Year
t the c by the	hysi	9 Unknown	9 ☐ Unknown								
w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions	contributing to death b	ut not resu	Iting in the un	derlying cause give	en in Part I.				the cause of death?
requir	ted							10	res 2 □ No	3 <b>₽</b> Pro	obably 4 Unknown
e law has t	Completed					····		24a. Was	an 24b osy rmed?	b. Were aut prior to c death?	topsy findings available completion of cause of
ificate		25. Was case referred to medical					00 51 (5	1 □ Yes	2 🗷 No		2 🗆 No
ysicle is cert direct	o Be	examiner?	Hospital: 1 ☐ Inpatio	ent 2 ∏ E	ER/Outpatien	t 3 DOA Oth	er: 4 ☐ Nursing Ho	ome 5 ☐ Resid		ther (Snec	situl Cosos ca
ng Ph fter th ineral	L:uc	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry iy, Year)	28b. Time of Injury	28c. Injur Work		28d. Describe h		- ' '	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
tendi leath. tor: A the fu	cati	2 Accident investigati 3 Suicide 6 Could not	ion be			M 1□	Yes 2 □ No				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ertification: To	4 Homicide determine		ury - At hoi c. <i>(Specify</i>	me, farm, stre	et, factory, office		28f. Location (3 City or Tov		nber or Ru	ral Route Number,
ospita hours ineral ly filled	alc	29a. Certifier 1 Certifying	Physician: To the best	of my knov	vledge, death	occurred at the til	me, date and place	, and due to the	cause(s) and	manner as	stated.
the Honin 24 the Fundamental Inches	Medical	one)	aminer: On the basis of and manner st	ated.							
5 vit	2	29b. Signature and title of certifier	10	;		29c. Licens	e number	-	29d. Date sign	ned (Month	Day, Year)
)	}	11 Int	my the	7	00-1/7	72	7 - 03		17090	21 -2	1
12		30. Name and address of person wh	o completed cause of c	leaπ (Item 6 Z	∠3a) (Type, F	N-Chu	les St.	fal	to mo	d 20	206
Sta		31. Date filed (Month, Day, Year)	2. Registr	ar's Signat	ure		-				
Registra	ar	AUG 2 6 201	08	1	Some						

08-0622	27	
Marilyn	K.	Love

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Marilyn K. Love		tment of Health and Mental H ificate of Death	ygiene Reg. No. 2008 2	737
Physician/	Decedent's Name (First, Middle,Last)	_	2. Date of Death 3. Time of Deat	th
Medical Examine	Marilyn Sue Love Marilyn K.  4a. Facility Name (if not institution, give street and number)	Love  4b. City, Town, or Location of Deatl	August 14, 2008 1403 hrs	
	2541 Chestnut Ridge Road	Grantsville	Garrett	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday) If Under 1 Year If Under 24Hr	s. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or	
Director	166-44-4179 1 M 2 XF 57	Yrs. Months Days Hours Mir	Nov. 17, 1950 中的Asylva	ania
<b>b</b>	Usual Residence of Decedent			
ow any		own or Location	10d. Inside City	
Aaryland 28a-f show 1 at once. ector	PA Westmoreland Moun	nt Pleasant	10g. Citizen of What Country?	20 110
the Maryland a or 28a-f sh tifted at one Director	753 Armbrust-Hecla Road	15666	U.S.A.	
with t		13. Was Decedent of Hispanic Origin? ( S	pecify Yes or No- 14. Race - American Indian, Black	k,
er death with or items 23 const be no Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto	Prican, etc.) White, etc.	
ral", c	3 Wildowed 4 21 Divorced in test Give tear	1 Yes 2 X No specify:	Specify: White	
"natu Exam		6a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ref		
hin 72 e. than tdical	12	Factory Worker	Respironics Corp.	
5-0036 ed within 72 hour dygene. other than "natu	17. Father's Name (First, Middle, Last)	<u>-</u>	e (First, Middle, Maiden Surname)	
121 I be fill ental H arked vent, I	Joseph A. Kiral	Lois Ha		
D 21 should and Mearl Ne mailt even			Rural Route Number, City or Town, State, Zip Code)	
and 2 lealth item 2 traum	Lois Kiral (Mother)  20a. Method of Disposition 20b. Pla	ace of Disposition (Name of cemetery,	Date   20c. Location - City or Town, State	<u>,6</u>
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	T Control of Temporal Total	ematory or other place) rel Hill Crematory 8-	19-08 Donegal, PA	
Iltin nit. Pa artmes oortan iry or	4 Donation 5 Other Specify, Latu 21. Signature   f Funeral Service Lipensee	22 Name and Address of Facility Galone—Caruso Fun	0 ,	
Balt permit, Departi Import injury	Donnie Illinu	P.U. Box 902 Moun	t PLeasant, PA 15666	
Physician	23a. Part I. Enter the disease, or complications that caused the death. D failure. List only one cause on each line.	o not enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart Approximate I Between Ons	
/Medical Examiner		xycodone intoxication	Death	
المد	b b b c to (ci as a consequence oi).			
ner	Sequentially list conditions, if any, leading to immediate onue. Enter Underlying Course			
a i	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
t0, e be executed ysician and burial - transit	d.			
0, e be exe ysician a burial -	X UNPENDED X AMENDED #1,23a,2	7,28a-f, perME, g884	10/3/08 TT	
ficate of ficate of fitter from from from from from from from fro	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregna		23d. Date of delivery	
). Box 6876( the death certificate by the attending phy ched for use as the the	past 12 months?  4 Pregnant at time of death	2 Fetal death 3 Ectopic pregn  h 5 Other (Specify)	ancy Month Day Ye	ar
BO le deat the att ted for	1 Yes 2 V No 9 Unknown g Unknown			
ires that the signed by be detach	Part II. Other significant conditions contributing to death but not rest	ulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of dea  1 Yes 2 ✔ No 3 Probably 4 Unk	
duires quires sign uld be			24a. Was an   24b. Were autopsy findings av	
Records, 1 The law requires fricate has been sig page 2 should be Completed			autopsy prior to completion of cau	
tal Rection: The certificate ector, page			1 Yes 2 No 1 Yes 2	No
Division of Vital Records, tal or Attending Physician: The law require rs after death.  The Director: After this certificate has been sited in by the funeral director, page 2 should bertification: To Be Completed ertification: To Be Completed	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 E	26.Place of Death (Check R/Outpatient 3 DOA Other Nursi	only one)  ng Home 5 Residence 6 ✓ Other: Scene	
of Vi	10 103 2 100	8b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred subject purposefully	
ion tendir eath. tor: A the fu	Natural 5 Dendin-	'nd 1:56 pm 1 Yes 2 X No	overdosed	
Division o spital or Attending tours after death.  The filled in by the fune Gertification:	3 X Suicide 6 Could not be 28e. Place of Injury - At hom	ne, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number or Town, State) 2541 Chestnut Ri	er, City
Division ospital or Attent ospital or Attent hours after death hours after to y filled in by the Certification	20a Certifier	in motel room	or Town, State) 2541 Chestnut Ri Rd. Grantsville, MD COmfor	FEOIN
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transi Medical Certification: To Be Completed by Physician/Medical E.	Constitution   Cons			
To To To Med	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)	
	Downy Dinkins	O.C.M.E.	August 15, 2008	
	30. Name and address of person who completed cause of death (Item 23)	3a)		
U	Donna M. Vincenti, MD Assistant Medical Examin		ID 21201	
State Registrar	(1) 4 U 4 U (1) (1) (1) (2) (2) (4) (4) (4)	1 Sparks		
Registia	7			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 244 per verb bergestern 15,000 per 15,000 pe 27380 Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 5:15 PM M William T. Leake July 18, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1 ☑ M 2 ☐ F 85 Nov 28, Director 1922 577<del>-</del>24-4487 North Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Experient is ust be notified at MD 1 ☐ Yes 2¶ No **Funeral Director** Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 630 Sheridan Street #510 20783 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWI] Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: \$ Specify: black 3 ☐ Widowed 4 ☑ Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.
27 Is marked other than rraumatic event, Inc. M. College (1-4or 5+) Elementary/Secondary (0-12) Print Press Operator unte state dept 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Leake ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katrell Lee/niece 16104 Parklawn Place Bowie, MD 20716 permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State ther (Specify) state Cheltenham Vet. Cem. 9-25-2008 Cheltenham, Md. vice Licens Carlton C. Douglas 22. Name and Address of Facility Pinckney-Spangler Funeral State Anatomy Board 524 8th St. North Street Baltimore, MD 21201524 8th St. North 20002 Rona. 1201 524 8th St. Washington, 20002 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** can U 0 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner nsequence of): at and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician the driving the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 □ Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 Accident 5 Pending hin 24 hours after death. the Funeral Director: A investigation 1 ☐Yes 2 ☐No filled in by the Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

AUG 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

6

32. Registrar's

ionature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	ryland / De	partment of ertificate of	Health Death	and Mer		iene 200	8 27381
	Physici /Medi		1. Decedent's Name (First, Middle, La	LIASO	2				Date of Death Month	Day Ye	
	Examir		4a. Facility Name (If not institution, given The Johns Hopkins	ospital		4b. City, Town, <b>Baltimor</b>	e City			4c. County of D	
	Funeral Director		5. Social Security Number 219–38–3645  Usual Residence of Decedent	XXM 2 F	(In yrs. last birthda Yrs.	Months Days		Min. 8.1	Date of Birth (Month, Day, Feb. 22,	Year) 1942	Birthplace (State or Foreign Country) MD
	Maryland -f show ed at	tor	10a. State 10b. County MD		10c. City, Town or		ltimore				10d. Inside City Limits  1 ☐ Yes 2 ☐ No
	death with the Maryland	Il Director	10e. Street and Number 27 North Rose Street	et		10f. Zip-Code	1224		10	g. Citizen of What	Country?
36	after or Ite	y Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 — Yes 2200 N	ver in U.S. 1:	B. Was Decedent of If Yes, specify Cul			Yes or No- n, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
Maryland 21215-0036	2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or Ite aumatic event, the Medical Examiner	Completed by	3 XWidowed 4 ☐ Divorced  15. Decedent's E (Specify only highest gr	Year or Dates: ducation ade completed)	(Gi	edent's Usual Occi le kind of work done DO NOT use retire	upation e during mos		1	Specify: B	
d 212	filed withi Hygiene. ther than nt, the M		Elementary/Secondary (0-12) 9 17. Father's Name (First, Middle, Last)	College (1-4 or 5-	+) ""	janitor	,	er's Name (Fi		Baltimore (	City
rylano	ould be Mental I narked o	Alfred Liason  P  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Numb)						I	Lula Mae		7.0.11
	and 2 sh fealth and m 27 Is n her traum		Lula Mae Liason /		701	Arlington A	venue;	Baltimor	re, Mary	land 2120	L
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any Injury or other traumatic event, the Medical once.		20a. Method of Disposition  1⅓∑3Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Speci	(y)		position (Name of ematory or other plants on Cemetery	- 1	Date 08/23/20		oc. Location - City	
Balt	permit. Departn Importa any Inju		21. Signature of Funeral Service Licer	cues		22. Name and Add	ress of Facilit mor Str	<sup>ty</sup> Wylie eet; Bal	Funeral	Home, P.A. Maryland	
	Physician		23a. Part 1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition		he death. Do not e	nter the mode of dy	ing, such as	s cardiac or re	spiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	304161116					50 min
V	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):			-			
,092	ate be executed hysician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a	consequence of):						
89	ertificat ling phy se as th	_ O L	IF FEMALE:	23c. If yes, outcome o	f prograncy						
P.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 4 Pregnant at t	2 ☐ Fetal death 3	☐ Ectopic pregnar ☐ Other (specify)	ісу			23d. Date of Month	delivery Day Year
	uires that signed by ald be deta		Part II. Other significant conditions		t not resulting in the	underlying cause	given in Part	1.	23e. Did toba		e to the cause of death?
of Vital Records,	The law requires ate has been sign page 2 should bu	Completed by	DIABETES M		TYPE	2			24a. Was an autopsy perform	ed?   death	
ital	rsician: The secriticate director, pa										Yes 2 ■ No
of V	Physic this cerral dire	2	1 ☐ Yes 2 🔀 No  27. Manner of Death	Hospital: 1 Inpatien  28a. Date of injury		III 3 DOA				nce 6 Other (S	pecify)
Division	or Attending Physician: after death. Director: After this certifica in by the funeral director,	Certification:	1  Natural 5  Pending 2  Accident investigation 3  Suicide 6  Could not b	(Month, Day	∕ear) Injury	M 1	ork? ]Yes 2 □ i	No ·			
Div	pital or Attendi ours after death. eral Director: A filled in by the fi	Certifi	4 Homicide determined	building, etc.					City or Town,	State)	r Rural Route Number,
	To the Hospital within 24 hours and the Funeral I completely filled	edica	one) 2 Medical Exam	ysician: To the best of niner: On the basis of e and manner state	examination and/or	th occurred at the t nvestigation, in my	ime, date an opinion, dea	nd place, and o ath occurred a	due to the ca at the time, da	use(s) and manner ate and place, and	r as stated. due to the cause(s)
	5 7 kit	Σ	29b. Signature and title of certifier	*			se number			d. Date signed (Mo	
		-	30. Name and address of person who	completed cause of de	. , , , , , , , , , , , , , , , , , , ,	e, Print)	S-0			106057	12 3008
	Sta Registr	3.5	TINA LATIMER 31. Date filed (Month, Pay, Year) 6 2 AUG 2 6 2	008 32 degistrar	s Signature.	RECENCY M	EDILANE	600 Nor	th Wolf	e St, Baltin	nore, MD, 21287
					- 4						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 4:00 PM Thomas Lewis 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Samaritan BALTIMORE Hospitel Good If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1**X**XM 2 ☐ F MD 216-34-4299 68 Feb. 19, 1940 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Baltimore txTxYes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2819 Cunningham Drive 21244 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∏ Yes 2 **XM**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2/12X No SpecifBlack 3 Widowed 45 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) pipefitter W.R. Grace 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Lewis, Sr. Irma Nelson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Courtney Lewis / Daughter 2819 Cunningham Drive; Baltimore, Maryland 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Xxurial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 08/14/2008 Randallstown, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPT1C SHOCK Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CONGESTIVE HEART FAILURE 1 | Yes 2 | No 3 | Probably 4 Donknown ABDOMINAL ADRILC ANEURISM 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? KIDNEY DISÉASE 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

3a or 28a-f show t be notified at

r than "natural", or items 23a the Medical Examiner must t

2 should be filed within 72 hours after and Mental Hygiene.

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygle Important: If Item 27 Is marked other th any injury or other traumatic event, the once.

Director

Funeral

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Baltimore,

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Records,

Vital

Physician/Medical Completed Certification: To To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Medical

CHRONIC 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide

4 ☐ Homicide

(Check only one)

29a. Certifier

5 ☐ Pending investigation

6 ☐ Could not be

Hospital: 1 Depatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

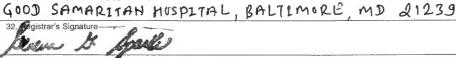
29b. Signature and title of certifier Bellane

29c. License number RES 000 29d. Date signed (Month, Day, Year) 08/15/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELBASE

31. Date filed (Month, Day, Year) State

2008 AUG 2 6



Registrar

State Registrar

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PRACHIJOG, GOOD SAMARITAN HOSPITAL, BALTIMORE MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Pay, Year) AUG 2 6 2008

RESODO

19/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** IOA /Medical 2008 Francis Lee 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner allimos nes Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7 Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days 1**X**☐ M 2☐ F 217-22-7933 Director 82 25 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "Actical Examir er must be notified at 1 Yes 2 □ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2513 Queen Ann Road Funeral 21216 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2X No Specify. ģ Specify: Black 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Accountant Fort Meade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental em 27 is marked or ပ Frank Lee Burnie Campbell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 other t 4509 Prospect Circle, Baltimore, Md 21216 Steven Lee-Son permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 8/29/2008 Owings Mills, Md 21. Signature of Funeral Service Linensee March F/H West 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 21215 Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-tra Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the I IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably certificate has been s rector, page 2 should I Completed 24b. Were autopsy findings available fior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes ₽ NO 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 N Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner Leath 1 Lural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 20965 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospitall, 9005 MEERASM BODDV 31. Date filed (Month, Day, Year) 32 Registrar's Signature

Registrar
DHMH 17 Rev 1/2001

AUG 2 6

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** LEWI 6.50 AM LANES D U G 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner order 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AnenE ARUMBEL WASHINGTON HOSY BAUTMORE If Under 1 Year 5. Social Security Number 6. Sex . Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Months **Director** 224.28.2415 MARCH 5, 1922 86 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Completed by Funeral Director MD ANNE ARUNDEL **GLEN BURNIE** 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō items 23a 7355 FURNACE BRANCH RD. 21060 USA 12. Was Decedent Ever in U.S. Armed Forms? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 □Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Pivorced "natural" WHITE 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **BOOKKEEPER** ARLINGTON COUNTY COUTRHOUSE 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည NORMAN GILROY LOLLIE BOWIE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 i SHIRLEY FURLONG 960 NABBS CREEK RD. GLEN BURNIE, MD 21061 20a. Method of Disposition \*\*Disposition 3 \*\*Removal from State\* 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o COLUMBIA) CARDENS CEMETERY ALLO 22, 2004 ARLINGTON, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility FINK FUNERAL HOME, P.A. 21. Signature | Fumeral Service Li GREGORY NK 426 CRAIN HWY SW GLEN BURNIE, MD 21061 M01148 23a. Part 1. Enter the disease, ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death or co k, or heart failure. List only Immediate Cause (Final **Physician** disease or condition resulting in death) / /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any least the Limme data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2/1No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 P.0. Division of Vital Records. After

death.

Certification: To

Medical

27. Manner of Death

1 ☐ Natural 2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Director: A in by the f within 24 hours a

> State Registrar

29c. License number

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c.

Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

00059190

JIMORE WASHINGTON

19.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Injury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

HOSP

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

SAL BAFFOE-BONNE 32 Registrar's Signature

31. Date filed (Month, Day, ) 6

7/0

5 Pending

investigation

6 Could not be determined

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / De 1 - State Registrar  State of Maryland / De Per dr., g88	partment of Health and I 2,08,26,08and ertificate of Death	Mental Hygier Reg. N	ne 2008 27386
			1. Decedent's Name (First, Middle, Last) John Peter	Lambooy	2. Date of Death Month	3. Time of Death
	Physici: /Medic		Dr. John Peter Lamboov	,	August	12 2008   6:10 AM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	4c. County of Death
			904 Huntsman Road	Towson		Baltimore
I	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		368-16-3258 <sup>1</sup> ♥ <sup>M 2□ F</sup> 93 Yrs.	Inontato Bayo Meare	12-06-191	4 Michigan
	pu »		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	aryla sho	5				1 □Yes 2 ☑ No
	he M	Director	MD Baltimore Towso		100	Citizen of What Country?
	with t	ä	10e. Street and Number	10f. Zip Code	109.	U.S.A.
	s 23	eral	904 Huntsman Road  11 Marital Status 12. Was Decedent Ever in U.S. 1:	21286	andify Von or No	14. Race - American Indian,
	item item	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married  12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Sp. 1f Yes, specify Cuban, Mexican, Puerton</li> </ol>	Rican, etc.)	Black, White, etc.
38	be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Eventing and profilled at	þ	3 Widowed 4 Divorced If Yes, Give 1942–1946	1 ☐ Yes 2 🗷 No Specify:		Specify: White
ş	2 hou	Completed	15. Decedent's Education 16a. De	cedent's Usual Occupation	16b.	Kind of Business/Industry
21215-003	filed within 72 Hygiene. other than "nai ent, the Medic	ble	(Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of work . DO NOT use retired)	king	
21	giene giene ir tha	E I	Elementary/Secondary (0-12) College (1-4or 5+) Pr	ofessor/Researcher		Biochemistry
Þ	should be filed von Mental Hygie marked other imatic event, tr	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maid	len Surname)
<u>a</u>	should be f and Mental I s marked of umatic eve	10 E	Karl Peter Lambooy	Janı	na Bauman	
Maryland	shot and h		19a. Informant's Name/Relationship (Type. Print) 19b. Ma	illing Address (Street and Number or Ru	ral Route Number, Cit	ty or Town, State, Zip Code)
Σ	and 2 alth 27 I		Irene Thelma Lambooy / Spouse 90	4 Huntsman Road, To	owson, Mary	yland 21286
altimore,	of He		20a. Method of Disposition 20b. Place of Dis	rematory or other place)		Location - City or Town, State
Ĕ	Page nent int: If		1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	de Cemetéry 08-2	:0-2008   <sub>Ka</sub> 1	amazoo, Michigan
Balt	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic es		21. Signature Mineral Syrvice Licensee	22. Name and Address of Facility R1050 York Road, R1	uck Towson	Funeral Home, Inc.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not			Approximate
	Dhusisian	2 16	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	The food we	Long di	Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):		-	
	Examiner		Due to (or as a consequence or).			
		ĕ	Sequentially list conditions, if any leading to immediate b. Duri to (or as a nonsequence of):			
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89	ntifica ng pt as th	Jed	TO SECULA			
Box	eath certific attending p for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant  1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delivery
E	e dear	Sici	1 Yes 2 No 4 Pregnant at time of death	5 Other (specify)		Month Day Year
<u>Ч</u>	w requires that the de been signed by the should be detached	چّ	9 Li Unknown			
Š,	as tha	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
ב	en s				1 ☐ Yes	2 No 3 Probably 4 Miknown
Vital Records,	law ra as be 2 sh	Completed	INSU DON'S		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
ř	The ate h	ĕ			performed	death?
<u>=</u>	sician: The law certificate has triector, page 2 s	Be	25. Was case referred to medical	26. Place of Dea	th (Check only one)	
>	nysic nis ce direc	0	examiner? 1   Yes   2   Revious   1   Inpatient   2   ER/Outpate	tient 3 DOA Other: 4 Nursing H	ome 5 Residence	e 6 ☐Other (Specify)
Division of	Attending Physician: sr death. ector: After this certific by the funeral director,	L ii	27. Manner of Death  12 Natural 5 □ Pending  28a. Date of Injury (Month, Day, Year)  28b. Time Injury		28d. Describe how in	njury occurred
<u> </u>	ath. or: At	aţic	2 Accident investigation	M 1 □Yes 2 □No		
<u> </u>	er de recto	≝	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, late)
	ital o ral Di led ir	Certification:				
	To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fun	edical	29a. Certifier (Check only  Check only  (Check only)  1 Certifying Physician: To the best of my knowledge, do  2 Medical Examiner: On the basis of examination and/o	eath occurred at the time, date and place r investigation, in my opinion, death occu	e, and due to the caus irred at the time. date	e(s) and manner as stated. and place, and due to the cause(s)
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	6 t v c	_	29b. Signature and the of conffier	29c. License number		Date signed (Month, Day, Year)
			1/000	2	2	> / >
	541		30. Name and address of person who completed cause of death (Item 23a) (Type Eddin Nakehuda M. D. 2200 Dullar race Va			24222
في	/		Eddie Nakhuda M.D., 2300 Dulaney Va 31. Date filed (Month, Day, Year) 32 Registrar's Signature		, Maryland	21093
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 2 6 2008 32/Flegistrar's Signature	perle		
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Dennis John Lambropoulos 2008 August 5:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson B**a**ltimore If Under 24 Hrs. 8. Date of Birth Sept 18, 1925 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1X M 2□ F Months Days Hours Min. Greece 212-36-0650 82 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits show ritems 23a or 28a-f should be notified at **Funeral Director** 1 ☐ Yes 2 X No Baltimore Md. Timonium 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2153 Suburban Greens Drive 21093 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or it any Injury or other traumatic event, the Medical Examinanty Injury or other traumatic event, the Medical Examinanty or other traumatic event, the Medical Examinations. Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Lambropoulos Athanasia Dionysopoulos ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Voula Lambropoulos/ Wife 2153 Suburban Greens Dr. Timonium, Md. 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Greek Orthodox Cem. 8-25-08 Woodlawn, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyneral Service Licens Rack<sup>nd</sup>†ddsson actual Home, 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death urinary sepsis 2° gram positive cocci in chains Immediate Cause (Final Physician more than 2 disease or condition resulting in death) /Medical dous Examiner more than 2 nephrolithiasis Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cletti Due to (or as a consequence of): law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Day Year signed by the a 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> Coronary arterydisease SID CABG 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown this certificate has been si al director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? Prostate cancer 24a. Was an autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) he Hospital or Attending P n 24 hours after death. The Funeral Director: After to pletely filled in by the funera 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4. Dinaano 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dimaano Rhett Gerard Paras

Registrar

State

31. Date filed (Month, Day, Year)

AUG 2 6

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 6:30 AM Wealie Larosa 21 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 2300 Dubney Valley Maris Timonium, Balt more If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth
(Month, Pay, Year)
Jan 24, 1946 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🛛 F Mărÿland Director 213-46-1063 62 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits Harford Joppa Md. 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 514 Trimble Road 21085 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②CNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No δ 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Johns Hopkins Elementary/Secondary (0-12) College (1-4or 5+) 12th Medical Surgery Tech Hospital permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othin any Injury or other traumatic event, ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest В. LaRosa , Sr. Sally McVicker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 514 Trimble Road Joppa, Md. 21085 Robin Blische (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 8-25-2008 Baltimore, Maryland 22. Name and Address of Facilikaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 175th 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** End-Stage /Medical Due to (or as a consequence of): **Examiner** FIBIOSIS umonay Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner with Seed Implants The law requires that the death certificate be executed Therapy physician and s the burial-trans Radiation Due to (or as a consequence of Division or Vital Records, P.O. Box 68760. Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 ponths? Month 4☐Pregnant at time of death 5 Other (specify) ed by the a 9☐ Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cardio myo 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a, Was an autopsy performed 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 ☐ Yes 2 ☐ NO 2 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours a filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month. Dav. Year) ШМ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar Robinson, MD

2008

31. Date filed (Month, Day, Year) AUG 2 5 20 22

32. Registrar's Signature

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filed within 72 hours after death with the Maryland

"natural";

1 and 2 should be filed within Health and Mental Hygiene. Iem 27 is marked other than

Maryland 21215-0036

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To the Funeral I

completely filled

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State Registrar

DHMH 17 Rev 1/2001

this

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Malling. A



and manner stated.

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

P 22257

29d. Date signed (Month, Day, Year)

AUG 23 4 2008

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** August 2008 9:45 A. M Naomi Estella Myers /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 614 Sherwood Road Baltimore County Cockeysville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Sept.05,1934 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Months Days Hours 1 □ M 2 🛱 F 73 Owings Mills, MD. Director 212-32-0803 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a State 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show diral Examiner must be notified at 1 □ Yes ŽŽŠNo Maryland Baltimore County Cockeysville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 614 Sherwood Road 21030 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ∏ Yes 2 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify White Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry traumatic event, the Medical College (1-4or 5+) n/a Elementary/Secondary (0-12) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Elizabeth Stroh ၉ Francis Albert Roberts 19a. Informant's Name/Relationship (Type. Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Orville Edgar Myers,Jr. 614 Sherwood Road Cockeysville, Maryland 21030 other t permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 23, August 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Evans Funeral Chapel 2008 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A.
2325 York Road Timonium, Maryland 21093 23a. Part Enter the disease or complications that paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause ob each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a nonsequence of) Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate has 1□ Yes 2 No Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 2 No Hospital: 5 Residence 6 □Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After or Attending 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2∏No death. after death Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Marklams MC 7) 1345 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

AUG 2 6

nt Valley Mc 2030

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 5:00 ДΜ Robert E. Myers 22. 2008 August 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Charlotte Hall Veterans Saint Marys Hane Charlotte Hall 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Months Days Hours Min 1**X** M 2□ F 213-18-8688 05/19/1920 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Parkvil le 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3202 Sperl Court 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 XNo If Yes, Give Year or Dates: WW TT Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City 12 Police Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Archie Myers Helen M. Gibert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leo J. King/ Step-son 3202 Sperl Court Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lavn Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 08/25 / 08 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 21. Signature of Funeral Service License 8800 Harford Rd. Parkville, MD 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm ciate Cause (Final dis se or condition DEBILIT dis se or condition resulting in death) Due to (or as a consequence of) DEMENTIF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARTERY 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 □Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one)

**Physician** /Medical Examiner Examiner and dis certificate be executed burial-transit

**Physician** 

/Medical

Examiner

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MD

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinating to Inditive at

12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r

permit. Pages 1 and 2 should be Department of Health and Menta Important; If Item 27 is marked any injury or other traumatic....

Baltimore, Maryland 21215-0036

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within 24 hours at To the Funeral D completely filled i

Box 68760,

P.O.

of Vital Records,

Division Hospital or Attending Physician/Medical Completed by Be Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 Unknown

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: 1 🗋 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending investigation

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier 200

6 Could not be determined

29c. License number D67788 29d. Date signed (Month, Day, Year) 8-22-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEENA

29449 Charlotte Hall Rd. Charlotte Hall, M.D. KODALI

State Registrar 31. Date filed (Month, Day, Year) AUG 2 6 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 3:55 P M 19 2008 James A. Mallin August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard 5870 Bellanca Drive Elkridge 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 → M 2 □ F Months Days Hours Director 112-20-5596 79 12-09-1928 New York Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location 28a-f show ral", or items 23a or 28a-f shov Director 1 ☐ Yes 2 No MD Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5870 Bellanca Drive 21075 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1951 1 ☐ Never Married 2 Narried Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates: 1 □Yes 2 🛛 No þ Specify Specify: 1953 3 ☐ Widowed 4 ☐ Divorced White Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, It. M. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Electrical Engineer Defense Aerospace 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Francis Edward Mallin <u>Margaret Mary Aylmer</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jacqueline M. Mallin - wife 5870 Bellanca Drive, Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State August. 4 Donation 5 Other (Specify) 21, 2008 Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Service 22. Name and Address of Facility Gary L. Kaufman Funeral Home at M00053 MMP, au Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ron **Physician** 1 4 YS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last physician and street the burial-transit The law requires that the death certificate be executed Exami Due to (or as a consequence of) Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page this certificate of Vital 2 No 1 ☐ Yes 2 X No 1 🗆 Yes Hospital or Attending Physician: 24 hours after death. director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To After the 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: , d in by the f 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 1 La Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

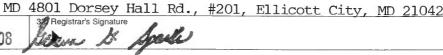
2011

Steven Eversley, 31. Date filed (Month, Day, Year) Registrar

AUG 2 6 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certif.



29d. Date signed (Month, Day, Year)

Ronald Wayne Meader Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-06388 **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 21, 2008 0522 hrs Ronald Wayne Meader Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Reltsville S/B Baltimore Washington Parkway If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** oreign Washington Days Hours Min 09-26-1959 Director 48 215-74-6791  $_{1}X_{M}$ 2 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 'n 10a, State 1 Yes 2XX No Anne Arundel Severn 28a-f show MD Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 23a or 28a-f notified at o USA 21144 7895 Chalice Road 14 Race - American Indian, Black, Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. tem 27 is marked other than "natural", or items traumatic event, the Medical Examiner must be White, etc. Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death 1 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Important: If item 27 is marked other than "natural", or item injury or other traumatic event, the Medical Examiner must b Armed Forces? 1 XXNever Married 2 Married 2 XX No Yes White Specify: If Yes, Give Year Yes 2 X No specify: Widowed Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Elevator Mechanic 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joyce Ann Wood Richard David Meader Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 215 Forest Glen Lane Pollocksville, NC 28573 Richard Meader (Father) 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place)
Meadowridge Memorial Park, 1 XXBurial 2 Cremation 3 Removal from State Inc 8/26/08 Elkridge, Maryland Donation 5 Other Specify 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, 21. Signature of Funeral Service Liçensee M0123 075 7250 Washington Blvd Elkridge. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury mat initiated Due to (or as a consequence of): events resulting in death) Last so the Hospital or Attending Physician: The saw requires that the death certificate be executed and Physician/Medical AMENDED physician the burial -UNPENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death led by the attending detached for use as t past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available certificate has been prior to completion of cause of autopsy performed? death? 1 🗸 No page ✓ Yes 2 26.Place of Death (Check only one) director, 25. Was case referred to medical of Vital Be examiner? Other; Residence 6 V Other: Scene ER/Outpatient 3 DOA Nursing Home 5 Inpatient 2 this 1 V Yes After th 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Driver of motorcycle involved motor vehicle FOUND: within 24 hours after death.

To the Funeral Director: A completely filled in by the fun 1 Natural 1 Yes 2 ✔ No Pending accident Aug 21, 2008 0511 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) S/B Baltimore Washington Parkway, Beltsville, MD (Specify) Interstate/Express Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated **Medical** (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) August 21, 2008 O.C.M.E. no 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 3. Registrar's Signature State 2008 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 27394 1 - For State Registra Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 Year Kathleen E. Moran August 24, 5:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Gilchrist If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1 □ M 2 🔀 F Months 213-58-1174 Yrs Director 56 6/5/1952 Maryland Usual Residence of Decedent the Maryland 10a. State 10b Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Funeral Director MD Baltimore Parkville 1 ☐Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items 23a or death with 2613 Meadowland Court 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Madical Evantre ODDs. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Realtor 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) Richard D. Moran ೭ Marian Myer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Teri Kelly / Partner 2613 Meadowland Court Parkville, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State 8/26/2008 Hilltop Serv. Corp. Towson, Marvland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** Due to (or as a cursequence of): disease or condition resulting in death) years /Medical Examiner Sequentially list conditions, if any, leading to immediate cause Enter Library Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-1 Due to (or as a consequence of): physiclan s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 No Month Year Dav certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 🕍 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Nother} \) (Specify) \( \text{WSPUL} \) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: d in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours aft te Funerai Di bletely filled ir To the Hosp within 24 hou To the Funel completely fil 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) D 583 v3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

AMUN S. CHAWRES WY 6701 N. Charles ST TONSON MO 21204

State Registrar

Registrar AUG 2 6 20

31. Date filed (Month, Day, Year)

32. pegistrar's Signature.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (Eirst, Middle, Last) 2. Date of Death **Physician** Brenda 12008 LOUST /Medical 4b. Gity, Town, or Location of Death 4a. Facility Name (If not institution, give street and nymber) 4c. County of Death Examiner NIA 5Nes Birthplace (State or Foreign Country) Social Security Number 6. Sex 7/ Age (In yrs, last birthday) Yrs. If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Year) 1 □ M 2 🗗 F Months Davs Hours Min 920 6 16,194 Director July. Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or Items 23a or 28a-f show 10b. County 10d. Inside City Limits 10a State 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at ZYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 61 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 No Specify. ģ 3 ☐ Widowed 4 ☑ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) afeteria NIA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) EnoLIA PKNIE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is, any injury or other trau Pages 1 and 2 s ment of Health ar Balto. avaso Ane Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 Burial 2 Sremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature Fureral Service Licen ee 12 milan 22. Name and Address of cility 0 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immedi re Cause (Final diseas or condition resulting in death) METASTATIC LUNG **Physician** YEAR /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a sunsequence of) attending physician and Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 3 Probably 4 Unknown 1 Yes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2. No 1 🗌 Yes 1 □Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 KER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D16354

State Registrar 900

32. Registrar's Signature

CATON AVE BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

AUG 2 6

2008

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Physicia /Modic		Registrar  1. Decedent's Name (First, Middle, Last)				Certificate of Death			2. Date of Death Month Day August 21, 2008		3. Time of Death 5:41 P. M		
/Medic Examina Funeral Director		4a. Facility Name (If not institution, g	give street and number) enue		4b. City, Town, or Location of Death Ocean City If Under 1 Year If Under 24 Hrs.			h	We with	c. County of Death	nplace (State or Foreign Intry) Maryland		
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventine must be notified at once.	Director					y, Town or Location  hearn  10f. Zip Code 10					10d. Inside City Limits 1 ☐ Yes 2 No  0g. Citizen of What Country?		
	by Funeral Di	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in I Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:			U.S. 13. Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric			Specify Yes or Noto Rican, etc.)	Inited States  14. Race - American Indian, Black, White, etc.  Specify: White				
	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  College (1-4or 5+)   7. Father's Name (First, Middle, Last)			16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  Secretart  18. Mother's Name				16b. Kind of Business/Industry  Medical  fiddle, Maiden Sumame)				
	To Be	Lionel Hopfield  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing					Evelyn N	n Williams or Rural Route Number, City or Town, State, Zip Code) 1timore, MD 21207					
		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spe  21. Signature of Funeral Service Lie	☐Removal from State	20b. Place ceme	of Dispo tery, crer	osition (Name of natory or other pla Cremator 2. Name and Addre	y August	25, 200	20c. l 8 G. rs I	Location - City or Len Burn Funeral I	Fown, State ie, Maryland Directors, Ir 21133-4784		
the death certificate be executed  The death certificate be executed  The attending physician and the attending physician and the for use as the burial-transit	ical Examiner	23a Part 1. Enter the disease, or company, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	the death. D	e of):	hic can				ease	Approximate Interval Between Onset and Death		
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yof 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							23d. Date of delivery Month Day Year				
requires that been signed b	þ	Part II. Other significant conditions contributing to death but not result hyper tension, atnal fr				brillation,			e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown				
cian: The law ertificate has ctor, page 2 s	Be Completed	24a. Was an autopsy findings available prior to completion of cause of death?  25. Was case referred to medical examiner?  26. Place of Death (Check only one)											
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Hoursal Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the temporary.	Certification: To	1 Yes 2 No Hospital: 1 Inpatient 2 El  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation investigation  28a. Date of Injury (Month, Day, Year)  28a. Date of Injury (Month, Day, Year)				ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ other (Specifivacation 28b. Time of Injury M							
	Medical Ce	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
To the virthi	Z	29b. Signature and little of certifier  29c. License number  29d. Date signed (Month, Day, Year)  August 22, 2008  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
Star Registra		ELLA GOLD LOC 31. Date filed (Month, Day, Year)	m mo	2 COS ar's Signature	ssm	ads Dr	Suite 40	ON1	ngs	Mills	MD 21/17		
		7,0000											

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of De	i leg	No. 2008 2/39
Physicia Medical Exami	an/	Decedent's Name (First, Middle,Last)	2. Date of Death Month August 22, 2	3. Time of Death 2008 1823 hrs
,			Town, or Location of Death	4c. County of Death
Funeral Director			nder 1 Year If Under 24Hrs. 8. Date of Birth ( https://doi.org/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001/10.1001	MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Maryland
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iow any		Maryland Baltimore		1 X Yes 2 No
arylane 8a-f sl	Director	10e. Street and Number 10f.	Zip Code 10g	. Citizen of What Country?
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MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show marite event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Dec	dent of Hispanic Origin? (Specify Yes or No- cify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
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2 hour "natu	eted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Us during most of	al Occupation (Give kind of work done 1 vorking life. DO NOT use retired)	6b. Kind of Business/Industry
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212 uld be Menta marke	o Be	Patrick O Doherty  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Addi	Rose Huggin	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical		20a. Method of Disposition  1 Burial 2 XCremation 3 Removal from State Atlantic Cr	ce)	20c. Location - City or Town, State Glen Burnie, MD
altin mit. Pa partmet portan		4 Donation 5 Other Specify:		
		She delt Marker 1630	nd Address of Facility Sterling As al Home of Catonsville Edmondson Avenue; Cat	onsville, MD 21228
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mo- failure. List only one causa on each line.		t, shock, or heart Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Narcotic (mornhine) in Due to (or as a consequence of):	oxication	
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	miner	cause. Enter Underlying Cause (Disease or injury that initiated		
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760, ficate be g physici	/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de	th 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
Box 68. he death certifi r the attending	Physician	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal de 4 Pregnant at time of death 5 Other (		Month Day Year
b. Bc the dea by the a	Phys	Part II. Other significant conditions contributing to death but not resulting in the under	ing cause given in Part I. 23e. Did toba	acco use contribute to the cause of death?
ires that the signed by I be detache	á		g g	2 No 3 Probably 4 Unknown
ords w requires been should	Completed		24a. Was an autopsy	prior to completion of cause of
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ital Recision: The scertificate	Be	25. Was case referred to medical examiner?	26.Place of Death (Check only one)  DOA Other Nursing Home 5 R	esidence 6 Other:
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ion tending eath or: A the fur	ation	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation Fnd 8/22/08 Fnd 5:35	pm <sup>1</sup> Yes 2 X No unk	
Division of Vital Records, pital or Attending Physician: The law requirours after death reral Director: After this certificate has been sfilled in by the funeral director, page 2 should	Certification	3 Suicide 6 X Could not be determined (Specify) found at hom	ory, office building, etc. 28f. Location (Str or Town, Sta	teet and Number or Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn		1 29a Centiler	the time, date and place, and due to the cause	s) and manner as stated.
To the withing To the comp	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated. 29b. Signature and title of certifier		29d. Date signed (Month, Day, Year)
		Dona Julias		August 23, 2008
X		30. Name and address of person who completed cause of death (Item 23a)	n Chroat Baltimore MAD 24204	
///	212		n Street, Baltimore, MD 21201	
Regist	ate trar	11115 2 11 /111111 12 22 22 24 24 24 24 24 24 24 24 24 24 24		

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		-	For State Registrar	State of Ma		partment of F ertificate of I			g. No. 2 1 1 2	27398
	Dhysici		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	al	Ruth Vivian Orda		Ordakowsk			August	21 2008	11:15PM
	Examin		4a. Facility Name (If not institution, give si		r	1	Location of Death		4c. County of Death	rundel
•			Crofton Convalesce  5. Social Security Number   6. Sex		Y e (In yrs. last birthda		If Under 24 Hrs.	8. Date of Birth	9. Birth	nplace (State or Foreign untry)
	Funeral Director		212-09-9921	M 25kF	90 Yrs.	Months   Davs	Hours Min.	(Month, Day, Nov. 11		uintry) MD
	nyland how		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	e Marisaris	5	Maryland Anne A	rundel			asadena			
	or 24	Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	s 23a	eral	393 Edgewater Roa		Tuna in II 6	2 Man Donadont of L	21122	pecify Ves or No-	USA 14. Race - Ame	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Modical Examitant must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	2. Was Decedent E Armed Forces? 1 □ Yes 2 □ N If Yes, Give X Year or Dates:	lo	3. Was Decedent of Head of He		Rican, etc.)	Black, White	
Baltimore, Maryland 21215-0036	in 72 hou "nature	Completed	15. Decedent's Educ (Specify only highest grade		(G	cedent's Usual Occupive kind of work done  b. DO NOT use retire	during most of work		6b. Kind of Business/l	Industry
212	with giene. r thar	mo	Elementary/Secondary (0-12)	College (1-4or 5	+)	Homemak	er		Househo	1d
ğ	other other rent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	faiden Surname)	
<u>lar</u>	Mental Mental arked or	To E	William O.	Smith			Agnes	М.	Eckert	
lar)	2 sho and I is ma	Ť	19a. Informant's Name/Relationship (Typ		. 1				City or Town, State, 2	Zip Code)
<u>ح</u>	and lealth m 27 her tr		Mitlon T. Ordakows	Kl Jr. (		3 Edgewate			MD ZIIZZ 20c. Location - City or	Town State
ō	ges 1 It of H If itel or otl		20a. Method of Disposition 1 ➡ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State		sposition (Name of crematory or other pla	i Aug.	26	-	
ᄩ	it. Pacrimen rtant: njury		4 □ Donation 5 □ Other (Specify)	. ^	Glen Ha	ven Cemete  22. Name and Addre	ry ;	2008 G	len Burnie	, Maryland
Bal	permi Depar Impor any ir	5 5	21. Signature of Funeral Service Livense	K. J		3111 Moun	tain Road	, Pasade	Funeral H	
П			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	atio the caused	the death. Do not ne.	enter the mode of dyi	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
-	Physician		Immediate Cause (Final disease or condition	11	revas au	lar D	LINE			Onset and Death
	/Medical Examiner		resulting in death)		a consequence of):					
	LAMIMIE	<u>.</u>	Sequentially list conditions, b		a consequence of):					
J	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Decdae of hur) that initiated events c	Due to (or as	a consequence on.					
	tificate be executed g physician and as the burial-transit	Xar	that initiated events cresulting in death) Last	Due to (or as	a consequence of):					
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O. Box	The law requires that the death certific attending pate has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date of de Month	livery Day Year
σ,	that ned by deta		Part II. Other significant conditions con	tributing to death b	ut not resulting in th	e underlying cause gi	ven in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
rds	w requires t s been signe s should be o	q pe	Dementia, De	hydrai	ion			1 □ Y€	s 2 No 3 □ P	robably 4 Unknown
Division of Vital Records,	aw re	Completed by		V				24a. Was a		utopsy findings available completion of cause of
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<u>_</u>	nysic nis ce I direc		examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 🔲 Inpatie	ent 2 ER/Outpa	atient 3 DOA Ot	her: 4 Nursing H	ome 5 Reside	ence 6 Other (Spe	ecify)
0	ng Pl	ü.:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ıry 28b. Tim ı <i>y, Year)</i> Inju	ry Wo	rk?	28d. Describe ho	ow injury occurred	
Sio	tendi leath. tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be	an Bloom that	At home form		]Yes 2□No	99f Location (C)	treet and Number or R	usal Pauta Numbar
$\leq$	for At after d Direct Jin by	Certification: To	4 Homicide determined	building, et	c. (Specify)	, street, factory, office		City or Town	n, State)	urar noute Number,
	pital ours a neral I		29a. Certifier 1 Certifying Phys	siclan: To the best	of my knowledge, o	leath occurred at the	time, date and place	e, and due to the c	ause(s) and manner a	as stated.
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2 // Medical Examinate)	ner: On the basis of and manner st	of examination and/o	or investigation, in my	opinion, death occu	irred at the time, d	late and place, and du	e to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier	1		29c. Licen	se number	2	9d. Date signed (Mon	th, Day, Year)
			· (r)·U	1		123	8958		8/22/0	of.
	10		30. Name and address of person who co	mpleted cause of	death (Item 23a) (Ty	pe, Print)	,	2 0	A 4	
	( )		Daljeet Signph	Sidhi	, 208 1	Crain Heg	Lway 5	w alu	1 Burne	MD21061
	Sta Regista		31. Date filed (Mohth, Day, Year)	8 Hegisti	rar's Signature	berte				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 1 per doc, 18-19b per fh g883 9-19-19b egible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Rosalie Ann O'Bier 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 3 33 AM 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Tohns Baltina City (coter N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Year) Months 1 M 2 KF 222-22-9737 Feb. 1938 70 18 Director DE. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits notified at Sussex Delaware Ellendale 1 ☐ Yes 2 ☐ No Director 28a-f 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ral", or items 23a or Examiner must be r 19941 USA 11480 Smith Road Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. l □ Yes 2 □ No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 反 No Completed by Specify: Specify: 3 XWidowed 4 ☐ Divorced Year or Dates: "natural" 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Retail/Walmart 12 Greeter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname)

Mary Myrtle Towers Be Department of Health and Mental I Important: If item 27 is marked of any Injury or other traumatic eve once. Mary Newton Sr. Cannon ပ 19a. Informant's Name/Relationship (Type. Print) O'Bier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald M. Smith Road, Ellendale, DE 19941 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 27 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Johnstown Cem. Greenwood, Delaware 4 Donation 5 Other (Specify) 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1 Enter the disease, or complications that caused the death bo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** millo schin disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed bunial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? jo Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown ò signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by disuse 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed' 2 🗆 🗖 o or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident the Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 ☐ Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00059189 8-27-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltime m 5 702 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

AUG 2 6

2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First Middle Last) 2.2 Day **Physician** 2008 12:50P M Mary Theresa Pirisino Aug. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 □ M 2 □ F Maryland 10/12/1932 212-30-0177 75 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10h County ed other than "natural", or items 23a or 28a-f show event, the Medical Evanting rough by retitling at 1 ☐ Yes 2 ☐ No Director Rosedale Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21237 4521 White Marsh Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2★No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Specify: White 1 ☐ Yes 2★☐ No Specify: If Yes, Give Year or Dates: Š 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8th Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tresa Creamer Frederick James ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4521 White Marsh Rd., Rosedale, Md. <u> Michael Pirisino (Husband)</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/27/2008 4 Donation 5 Nother (Specify) entombment Parkwood Mausoleum Baltimore, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Schimunek Funeral Home, Inc. 9705 Belair Road, Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician rear disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. End the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trar Due to (or as a consequence of) Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760, P.O. of Vital Records, Division

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

requires that the death certificate be executed physician attending properties for use as been signed by the should be detached cate has by page 2 s this certificate or Attending Physician: After thi funeral of within 24 hours arter com.

To the Funeral Director: Aff

To the Funeral Director: Aff To the Hospital

Medical

4 Homicide

(Check only one)

29a Certifier

Registrar

29b. Signature and title of certifie

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Charles St. Balts my 2:204 6701 GBINC 10

Day, Year, 31. Date filed (Month, AUG 2 6

determined

and manner stated.

**Physician** /Medical Examiner

or 28a-f show

"natural", or items 23a

Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed 1as within 24 hours after death

To the Funeral Director:
completely filled in by the

Division of Vital Records, P.O. Box 68760,

Completed by Be Certification: To Medical

End Stage	Renal Dise	1 ☐ Yes 2[	□ No 3 □ Probably 4 Unknown		
Diabetes				24a. Was an autopsy performed? 1 □Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
5. Was case referred to medical			26. Place of Dea	th (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2	ER/Outpatient 3 🗆 [	OOA Other: 4 Nursing H	ome 5 ☐ Residence	S □Other (Specify)
7. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investig	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	y occurred
3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		home, farm, street, facto	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
	g Physician: To the best of my ki examiner: On the basis of examinand manner stated.				

29c. License number

D0053312

29d. Date signed (Month, Day, Year)

Cedar Lane, Columbia, MA 21044

August 20, 2008

DHMH 17 Rev 1/2001

State Registrar

Henggeler, MD Michelle 31. Date filed (Month, Day, Year)

AUG 2

30. Name and address of persop who completed cause of death (Item 23a) (Type, Print)

29b. Signature and

32. Begistrar's Signature

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**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-06384 State of Maryland / Department of Health and Mental Hygiene Peggy Palmer 2008 27402 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0148 hrs August 21, 2008 Medical Examiner Palmer Peggv 4c. County of Death 4b. City. Town, or Location of Death 4a, Facility Name (if not institution, give street and number **Baltimore** N/A Union Memorial Hospital g. Birthplace (State or Foreign Mary Land 8. Date of Birth (MM/DD/YYYY If Linder 1 Year | If Linder 24Hrs 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director 1955 Country) 217-64-7330 M 2X F 53 Mar 24, Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 X Yes 2 No Baltimore Maryland N/A within 72 hours after death with the Maryland 10g. Citizen of What Country 10f, Zip Code 10e. Street and Number notified at 21218 USA 3518 Beech Avenue Apt. E. 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status 12. Was Decedent Ever in U.S. must be "natural", or items Armed Forces? Never Married Marrie 2 X No Yes Black Specify: If Yes, Give Year Yes 2 X No specify. event, the Medical Examiner Widowed 4 X Divorced \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) it: If item 27 is marked other than other traumatic event, the Medical imore, MD 21215-0036
Pages I and 2 should be filed within 73
nent of Health and Mental Hygiene. Sales 1 Telemarketer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances Satterfield Be William Palmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1513 Highland Street Richmond, VA 23222 Theressa Safewright, Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Burial 2 X Cremation 3 Removal from State 08/23/08 Metro Crematory Inc. Baltimore, Maryland ment c Donation 5 Other Specify 5 Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service License Thomas Gregory 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED UNPENDED attending physician for use as the burial of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Year Day Live birth Fetal death Ectopic pregnancy Month ned by the attending detached for use as t past 12 months Pregnant at time of death 5 Other (Specify) Yes 2 No 9 ✔ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. icate has been signed by it page 2 should be detached ģ 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed' Yes 2 V No 26. Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medica director. Be Other<sub>4</sub> Hospital: 1 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 DΩA Inpatient this ٩ 1 Yes uneral 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28b. Time of Injury After 27. Manner of Death Certification: 1 V Natural 1 Yes 2 No Pending 24 hours after death. the 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within ; and manner stated 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.F. August 21, 2008 april 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD Assistant Medical Examiner Registrar's Signature 31. Date filed (Month, Day, Year) State AUG Registra ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 800 leather 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Bon Secours Hospital Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 15, 1932 5. Social Security Number 7. Age (In vrs. last birthdav If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 🎞 F Months Hours Min. 214-26-9733 76 SC Director Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examirer must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Director 1⊠Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2541 Edmondson Avenue 21223 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian 1 ∐Yes 2√2 If Yes, Give Year or Dates: 1 Never Married 2 Married 20X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2√No Specify. ₽ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) healthcare provider nursing home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Elliott Jenkins Anna Ludd ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reather M. Jenkins / Daughter 2564 W. Baltimore Street; Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State TXBurial 2 Cremation 3 Removal from State Mount Zion Cemetery 08/22/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 MOL 23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed sician and burial-transit Due to (or as a consequence of P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown npletely filled in by the funeral director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 0000 24a. Was an has autopsy performed? Yes 2 No certificate I ☐Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 6 M 08 0 30. Name and address of person who completed cause of death (Item 23a) (Type) Print)

State Registrar

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Registrar's Signature

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31. Date filed (Month, Pay,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death edent's Name (First, Middle, Last) **Physician** owe ZOOX /Medical 4c. County of Death ocation of Death 4a. Facility Name (If not institution, give street and number mone Under 24 Hrs. Birthplace (State or Foreign Country) ial Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 □ M 200 F 40 212-86-3955 **Director** Oct. 24, 1967 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be notified at 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 231 N. Calhoun Street Apt. 101 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify. Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) laborer janitorial service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jean Robinson Jerry Powell, Sr. 19a. Informant's Name/Relationship (Type. Print)

Jackie Franklin / Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt. 101; Baltimore, Maryland 21223 231 N. Calhoun Street Baltimore, Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of 08/27/2008 Baltimore, Maryland Trinity Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 Approximate Interval Between Onset and Death 23a. P ... Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. finediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or at a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine that initiated events resulting in death) Last The law requires that the death certificate be exe Physician/Medical attending philips at the attention of th IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 ☐ Unknown Other significant conditions contributing to de 23e. Did tobacco use contribute to the cause of death? Vital Records, Be Completed by 2 Probably 4 ☐ Unknown 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 ENO as case referred to medical examiner? Physician: funeral director, 26. Place of Death (Check only one: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 2 N 1 Dipatient 2 ER/Outpatient 3 DOA Certification: To 0 this 28a. Date of Injury (Month, Day Year) 27. Manner eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Hospitai or Attending 2 Hatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. \*\*Descripting Physician: To the best of my knowledge, dearn occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier and address of person who complet Day, Year) State AUG 2 6 2008

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Registrar

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	ľ	for State Registrar			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		ertificate of			Reg. No.	2008	2740
Physicia /Medic		1. Decedent's Nam	e (First, Middle,	LOIS	G. PA	ULSE	:N		2. Date of D Month AUG •	Day	Year 2008	3. Time of Death  1:00 P <sup>M</sup>
Examin		4a. Facility Name (	If not institution,	give street and numbe	er)		4b. City, Town, o	r Location of Death	1100.		County of Death	11.00 1
		322 KL	EE MIL	L RD.			SYKES	VILLE			CARROL	L
Funeral Director		5. Social Security N 217-16-	1042	. Sex 7 1 □ M 2 💢 F	Age (In yrs. I		Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D 8 / 26 /	ay, Year)	Coui	place (State or Foreign htry) YLAND
and w		Usual Residence of 10a. State	10b. County		10c. City	y, Town or	Location				1	0d. Inside City Limits
e Marylan Ba-f show	ctor	MD	CARRO	LL			SVILLE					1 □Yes 21X No
th with the	Funeral Director	10e. Street and Nur 322 KI	mber LEE MII	L RD.			10f. Zip Code 21 78	34		10g. Citize	en of What Cour	ntry?
by by	þ	11. Marital Status 1 XNever Marr 3	ied 2☐ Married	12. Was Decede Armed Force 1  Yes 2 If Yes, Give Year or Date	s? <b>X</b> No	S. 1	3. Was Decedent of H If Yes, specify Cuba 1 □Yes 2 X No	lispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yes or N Rican, etc.)		4. Race - Americ Black, White, Specify: WH	etc.
in 72 h	Completed			grade completed)		(Gi	cedent's Usual Occup ive kind of work done e. DO NOT use retired	during most of work	ing	16b. Kind	d of Business/In	dustry
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al Hy l othe vent,	Be	17. Father's Name	(First, Middle, La	ist)				18. Mother's Nam	e (First, Middle	e, Maiden S	Gurname)	
Ment Ment rrked	70		M	ARTIN H.	K. F	PAULS	SEN	ETHEL	M. S	HERR]	ECK	
and l	П	19a. Informant's N	ame/Relationship	(Type. Print)		19b. Ma	ailing Address (Street	and Number or Rui	ral Route Num	ber, City or	Town, State, Zip	Code)
and and in 27 in 27 ier tr		STEVEN	PAULSE	N - NEP	HEW	32:	2 KLEE M	ILL RD.,	SYKE	SVILI	E, MD	21784
Pages 1 ent of H nt: If iter ry or oth			•	Removal from Sta	te		sposition (Name of rematory or other place TY CREMA		Date		ation - City or To	•
permit. P Departm Importar any Injur		21. Signature of Fu			7	COON		ess of Facility ${ m FL}$	ETCHER	FUN	ERAL H	OME, P.A.
				om wations that causely one cause on each	sed the death	n. Do not	enter the mode of dyi					Approximate Interval Between
Physician /Medical		Immediate Cause disease or condition resulting in death)	on				EMBOLUS				1	Onset and Death  INUTES
Examiner					as a consequ		IMMOBILI	πv			,	40NIIII C
		Sequentially list co	nditions	b. <u>F1</u>	YOU OIM	ريدن	THIODIPT	T T			P	10NTHS

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown

23c. If yes, outcome of pregnance
1 Live birth 2 Fetal d
4 December 4 November

1 🗆	Live	birth	2 🗆	Fet	al dea
4 🗌	Preg	nant a	at tim	e of	death
9 🗌	Unk	nown			

Due to (or as a consequence of)

Due to (or as a consequence of):

2 Feton	ic pregnancy
5 🗌 Other	(enocify)
2 - 01161	(Specify)

23d. Date of	delivery
Month	Day

23e.	Did tobac	co use con	tribute to the cau	se of death?
	1 🗋 Yes	2 📉 No	3 Probably	4 🔲 Unknowi

Part II. Other significan	t conditions contributing	g to death but not result	ting in the underlying c	ause given in Part

No	3 🗌	Probably	4 🗆	Unknown
24h	Were	autoney	findings	available

Year

	24a. Was an autopsy performed? 1 □Yes 2 ☒ No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
((	Check only one)	

25. Was case referred to medical examiner?			26. Place of Death (Check only one)									
1 ☐ Ye		0	Hospital:	: 1 ☐ Inpatient	2 🗆	ER/Outpatient	3 🗆 1	DOA	Other: 4	☐ Nursing He	ome	5 ☑ Residence 6 ☐ Other (Specify)
27, Manner 1 <b>X</b> Na 2 □ Acc	tural	5 ☐ Pending investigation		Date of Injury (Month, Day, Ye	ar)	28b. Time of Injury	M	28c.	Injury at Work? 1 □ Yes		28d.	Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide		6 Could not be determined	28e.	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f.	Location (Street and Number or Rural Route Num City or Town, State)		

4 LI Homicide	building, etc. (Specify)
29a. Certifier	1 Certifying hysician: To the best of my knowledge, death of 2 Medical Examiner: On the basis of examination and/or invest
(Check only	2 Medical Examiner: On the basis of examination and/or invest

occurred at the time, date and place, and due to the cause(s) and manner as stated.
estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s

one)    Medicar Examiner: On the basis of examination and and marrier stated.	/or investigation, in my opinion, death occurred at th	e time, date and place, and due to the cause(
29b. Signature and title of certains	29c. License number	29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print) WESTMINSTER, MD

D0000577

215 WASHINGTON HEIGHTS MEDICAL CTR. 21157

8/26/08

M. SUSAN BOLLINGER
31. Date filed (Month, Day, Year)
AUG 2 6 2008 MD Registrar's Signature

Division of Vital Records, P.O. Box 68760

		1 _ State	ndelible Ink. Ensure Al partment of Health and M ertificate of Death	lental Hygi	-	
Physicia	_	1. Decedent's Name (First, Middle, Last)  Doris R. Putman	Standard of Board	2. Date of Death Month August		
/Medic Examin		4a. Facility Name (If not institution, give street and number) 105 Margaret Avenue	4b. City, Town, or Location of Death Pasadena		4c. County of Death Anne Arundel	
Funeral Director		5. Social Security Number 216-12-3886 C. Sex 1 □ M 2 □ F 7. Age (In yrs. last birthda) 86 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, March 02	Year) 2 1922 9. Birthplace (State or Foreign Country) MD	
Maryland a-f show	ctor	10a. State 10b. County 10c. City, Town or to Maryland Anne Arundel	Location		10d. Inside City Limits 1 □ Yes 2 ☑ No	
th with the 23a or 28 let be not	al Director	10e. Street and Number 105 Margaret Avenue	10f. Zip Code 21122	10	g. Citizen of What Country? USA	
urs after dear al", or Items	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 No  If Yes, Give  Year or Dates:	3. Was Decedent of Hispanic Origin? (Spin If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
within 72 ho ene. than "natur	Completed	(Specify only highest grade completed) (Giv	vedent's Usual Occupation ve kind of work done during most of worki DO NOT use retired) Salesperson	ng 1	6b. Kind of Business/Industry  Departmant Stores	
uld be filed Mental Hygi rrked other rtic event, u	To Be Co	17. Father's Name (First, Middle, Last) William T. Beltz	18. Mother's Name Ruth			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is "stand be milled at once.		Sharon D. Putman (daughter) 105  20a. Method of Disposition 20b. Place of Disposition		Pasadena Date 2		
ermit. Page Department mportant: II iny injury o		4□Donation 5□Other (Specify) Metro Cr	rematory Inc. 20  22. Name and Address of Facility S	tallings	altimore, Maryland Funeral Home, P.A.	
Physician /Medical Examiner	ar.	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	3111 Mountain Roa	or respiratory arre	est, Approximate	
cate be executed oblysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):				
The law requires that the death certificate rate has been signed by the attending physpage 2 should be detached for use as the	Physician/Medic	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 24 No 9 □ Unknown  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3  4 □ Pregnant at time of death 5		23d. Date of delivery Month Day Year		
equires tha	ρ	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tob	acco use contribute to the cause of death? s 2 No 3 Probably 4 Unknown	
Ician: The law racertificate has be ector, page 2 sh	Completed	Serzue Distriction 25. Was case referred to medical	00 Photo of Positi	1.0.70	prior to completion of cause of death? No 1 □ Yes 2 □ No	
hysicia nis cer i direct	To Be	examiner? 1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpati	26. Place of Death ient 3 □ DOA Other: 4 □ Nursing Ho		nce 6 ☐ Other (Specify)	
Attending Physician: r death. ector: After this certific by the funeral director,	Certification:	27. Manner of Death  1 ★ Natural 5 Pending (Month, Day, Year)  2 Accident investigation  3 Suicide 6 Could not be		28d. Describe ho	w injury occurred	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		4 Homicide determined 200. Place of Injury - At nome, farm, s	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
the Hosp thin 24 ho the Fune mpletely fi	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	red at the time, da	ate and place, and due to the cause(s)	
) N /	-	29b. Signature and little of certifier	29c. License number D 4 24 20		9d. Date signed (Month, Day, Year) 8/25/08	
Sta	te	30. Name and address of person who completed cause of death (Item 23a) (Type Christopher de Borja, 370g) 31. Date filed (Month, Day, Year) 32. Prostrar's Signature	Mountain F	ed Po	sadera, mo 21122	
Registr	ar	AUG 2 6 2008 Seems At	forth			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) AUGUST 2I 200\bar{8}^a 1:20 Рм PECK EVE 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 10 Months | Days | 10 Months | 10 Mon 9. Birthplace (State or Foreign Country) MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 K F 91 212-01-2823 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a, State 1 □Yes 2 No BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21204 615 CHESTNUT AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 1

Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: Specify: 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BALTO. MUSEUM OF ART **ADMINISTRATOR** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DEUTCH SILBERT REBECCA BENJAMIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2901 NE BLAKELEY ST., #531, SEATTLE, WA DAVID PECK / GRANDSON 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State 08/24/2008 BALTIMORE, MD HEBREW YOUNG MEN 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Correct ears disease or condition resulting in death) Due to (or as a nsequence of): non Sequentially list conditions, if any leading L. it me diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) JYes 2 ☑ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. heart disease 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ☐ C 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 🖪 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Examiner certificate be executed and -trar physician a sthe burialattending for use as Box signed by the o Records, has certificate Vital After this certific funeral director,

Physician

/Medical

Examiner

Funeral Director

Completed by

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Certification: To

Medical

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**Funeral** 

Director

d 2 should be filed within 72 hours after death with the Maryland thit and Mental Hygiene. Prise is a marked other than "natural", or items 23a or 28a-f show traumatic event, the Marical Examinar Insert is maritied at

item 27 i

Department of F Important: If ite any Injury or oth

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

Division of

To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier uno

and manner stated.

30. Name and address of person who completed partie of death (Item 23a) (Type, Print)

L& 4 GBONC

6701 N. Charles St. Bolto. and Eccak

31. Date filed (Month, Day, Year) AUG 2 6 2008

4 Homicide

(Check only

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Robert Anthony Quille August 2008 12:15 P 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 800 West Lexington Street Apt. 1 Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1**X** M 2□ F 216-32-5043 69 Jan. 18, 1939 MD Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1,⊒Yes 2 □ No MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 800 West Lexington Street; 21201 Apt. 1 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give — Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 □Yes 2 XXIIo Specify Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 construction company laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Quille, Sr. Christine Spruel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doretha Quille / Sister-in-law 2240 East Chase Street; Baltimore, Maryland 21213 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 108/22/2008 Catonsville, Maryland 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service License 638 N. Gilmor Street; Baltimore, Maryland 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lay h e Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of): to (or as a consequ nce of) If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 □ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 1 ☐ Yes 2 **1** No 1 ☐ Yes 2 🗆 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 S Besidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Feath

**Physician** /Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed and

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

Director

Funeral

2

Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Modical Examiner must be notified as once.

Baltimore, Maryland 21215-0036

Examiner burial-transit attending physician for use as the buria Physician/Medical signed by the a \$ cate has been signal page 2 should be Completed certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be Certification: To

Division of Vital Records, P.O. Box 68760,

23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown 25. Was case referred to medical examiner? 

28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

29a, Certifier (Check only one)

1 Unural

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature a

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who con

2008

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7au 31. Date filed (Month, Day, Year)

State Registrar

Medical

the

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		I- For State Registrar	Certificate o	f Death	Reg	. No. 200	8 2740
Physici	an/	Decedent's Name (First, Middle,Last)			2. Date of Death Month	Day Year	3. Time of Death 2210 hrs
ledical Exami	ner	Charles Francis Robi  4a. Facility Name (if not institution, give street a	and the state of t	4b. City, Town, or Location of	August 21,	2008 4c. County of Death	22101115
		Harbor Hospital Center	and number)	Baltimore	· .	N/A	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under		(MM/DD/YYYY) 9. Birth	place (State or Foreign
Director		217-28-9685   1X M 2	76 Yr.	Months Days Hours	Min. Sep. 2	0, 1931 Cour	Maryland
»		Usual Residence of Decedent	10c. City, Town or Loca	tion			10d. Inside City Limits
ow any		10a. State 10b. County PA Berks		illington		1	1 Yes 2 No
faryland 28a-f show Lat once.	Director	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Count	
ith the Maryland 23a or 28a-f sho		717 Loblolly Lane		19607	7	United Stat	es
D 21215-0036 should be filed with the Maryland should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she atte event, the Medical Examiner must be motified at once	eral			as Decedent of Hispanic Origin Yes, specify Cuban, Mexican, I		14. Race - Americ White, etc.	an Indian, Black,
er dea	Fun		Yes 2 X No	Yes 2 X No specify:		Specify: [Jhi	
urs afi tural'	d b	15. Decedent's Education (Specify only higher	st grade completed) 16a. Decede	nt's Usual Occupation (Give ki		Specify: Whi  16b. Kind of Business/In	
5 72 ho in "na cal Ex	ompleted		lege (1-4 or 5+)	nost of working life. DO NOT u	se retired)		1 7
5-0036 led within 72 Hygiene. other than the Medical	duc	12		Carpenter		Constru	ction
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be C	17. Father's Name (First, Middle, Last)  Charles Robinette			Name (First, Middle, Madeline Rit		
212 212 ould, be   Ment   mark	9	19a. Informant's Name/Relationship (Type, Prin	nt ) 19b. Mailir	ig Address (Street and Numb			Zip Code)
MD id 2 sho lith and m 27 is aumati		Kim Metcalf - Daught		Loblolly Lane,	Shillingt	on, PA 1960	7
nore, MD 2 ages I and 2 shou nt of Health and N tt: If item 27 is n other traumatic		20a. Method of Disposition  Y Burial 2 Cremation 3 Rem		sition (Name of cemetery, ther place) W Memorial		20c. Location - City or T	own, State
Baltimore, permit. Pages I an Department of Hee Important: If ite	1	4 Donation 5 Other Specify:	Do IV Do	rlz l	8-26-2008	Eldersbur	g, MD
Baltimore, ME permit. Pages I and 2 s Department of Health as Important: If item 27 injury or other trauma	1	21. S. nature Fune S. rvice Lio nice	7 1 0 A 22.	Name and Address of Facility	Ambrose Fu	neral Home,	Inc.
Physician		23a. Part I. Enter the disease, or complications	that caused the death. Do not enter	328 Sulphur St the mode of dying, such as ca	rdiac or respiratory arre	st, shock, or heart	Approximate Interval
/Medical *xaminer	8 1	failure. List only one cause on each line.  Immediate Cause (Final disease a. Head	and Neck Injuries				Between Onset and Death
Adminier		or condition resulting in death)  Due to (	or as a consequence of):				
	er		or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	or as a consequence of):				
nd nd ransit		events resulting in death) Last Due to (	or as a consequence on.				
Records, P.O. Box 68760, The law requires that the death cutificate be executed cate has been signed by the attending physician and page 2 should be detached for us, as the burial - transit	Medical	UNPENDED	#DED				_
760, ficate be g physics the buri		IF FEMALE: 23c. 23b. Was decedent pregnant in the	If yes, outcome of pregnancy	2 Estania	promponov	23d. Date of delivery Month D	ay Year
that the death critificate by the attending detached for us, as the detached for us, as the same of th	Physician	past 12 months?	Prognant at time of death	etal death 3Ectopic other (Specify)	pregnancy	World	ay Year
Bo ne deat the at	hys	1 Yes 2 No 9 Unknown g	Unknown			1	
P.O. es that things igned by be detach	β	Part II. Other significant conditions contrib	uting to death but not resulting in the	underlying cause given in Par		bacco use contribute to t	
cords, P.O. law requires that: has been signed b	Completed				24a. Was a		opsy findings available
e law r e has b ge 2 sh	mpl				autops perfori	med? death?	ompletion of cause of
		25. Was case referred to medical		26.Place of Death (	1 Yes 2 Check only one)	No 1 ✓ Ye	s 2 No
Vita tysicia this cer direct	o Be	examiner? 1 ✓ Yes 2 No	1 Inpatient 2 🗸 ER/Outpatier	nt 3 DOA Other	Nursing Home 5	Residence 6 Other	
of Vital Rec	-	27. Manner of Death 28a	Date of Injury 28b. Time of (Month, Day Year) 2128 hrs		Subject fell	ow injury occurred	
Sion Attend death. ctor:	atio	2 🗸 Accident Investigation		1 Yes 2 ✔	No -		
Division of Vital Records, spital or Attending Physician: The law require ours after death.  reral Director: After this certificate has been si filled in by the funeral director, page 2 should b	Certification:	Suicide Could not be	e. Place of Injury - At home, farm, str pecify) Back Yard	eet, factory, office building, etc	or Town, St	treet and Number or Ru late) Ienry Drive, Baltimore	
in a spirit		20a Cartifier	the best of my knowledge, death occi	urred at the time, date and place			
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the	basis of examination and/or investig				
- > - 0	ž	29b. Signature and title of certifier	<u> </u>	29c. License number		29d. Date signed (Mor	nth, Day, Year)
		Coud Hal	ver	O.C.M.E.		August 22, 2008	
И		<ol> <li>Name and address of person who complete Carol Allan, MD Assistant Med</li> </ol>		Street, Baltimore, MD	21201		
S	tate	31. Date filed (Month, Day, Year)		arti			
Regis	trar	MAPP S P SONO	Language of the				

30. Name and eddress of person who com

C)

31. Date filed (

Please	e Type or Prir	t in Bl	lack Inc	delibl	e ink.	Ensure A	All (	Copies Are	Legi	ble.
_ For	State of Ma	aryland	l / Depa	ırtmei	nt of H	lealth and	Me	ntal Hygien	е	
<ul> <li>State Registrar</li> </ul>			Cer	tifica	te of	Death		Reg. N	0.21	108 27410
1. Decedent's Name (First, Middle, L	.ast)						2.	Date of Death	ay .	3. Time of Death
Vernon G. Reich	ert						$\Box A$	ugust à	2/0	1008 715 AM
4a. Facility Name (If not institution, g	ive street and number)			4b. City	Town, or	r Location of Deat	th	4	C. County	of Death
Social Security Number 6.		e (In yrs. la	st birthday)	If Unde	r 1 Year Days	If Under 24 Hrs Hours Min.		. Date of Birth (Month, Day, Year	()	9. Birthplace (State or Foreign Country)
214-34-4799	1 X M 2 □ F	89	Yrs.	Months	Days	Hours Min.		2-7-1918	'	Md.
Usual Residence of Decedent		40- 07-	Town or Lo							Land to the Company
Md. 10b. County	rford	TUC. City,	Fall		ì.					10d. Inside City Limits 1   1   1    1
10e. Street and Number				10f. Zi	ip Code			10g. C	itizen of V	Vhat Country?
3511 Fallston	Rd.				2104	7			USA	
11. Marital Status	12. Was Decedent I	Ever in U.S	. 13. V	Vas Dece	edent of H	lispanic Origin? (S an, Mexicen, Puer	Specif		14. Rac	e - American Indian,
1 ☐ Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 📉 f	ю				an, mexicen, Puer Specify:	IO HIC	uan, etc.)		k, White, etc.
3 Widowed 4 Divorced	Year or Dates:			I □ Yes	2 <b>X</b> 1 No	Specify:			Specify	" White
15. Decedent's (Specify only highest g	Education grade completed)		16a. Deced	kind of w	ork done	during most of wo	rking	16b.	Kind of Bu	usiness/Industry
Elementary/Secondary (0-12) 7 th	College (1-4or 5	+)	_	mer	use retired	1)			Agri	culture
17. Father's Name (First, Middle, Las	st)					18. Mother's Na	me (F	First, Middle, Maide		
William Reiche	rt					Ameli	a E	Bulcher		
19a. Informant's Name/Relationship Marian R. Reich	,	e		-				Route Number, City		
20a. Method of Disposition  1		cei	ace of Dispo metery, cren John	natory or	other plac	ce) Luth. 8-	Date 26-	]	Location -	City or Town, State
21. Signature Francis Service Lie		,	22	. Name e	end Addre	ss of Facility	Sc	chimunek tingham,		
23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that caused ly one cause on each line a. Due to (o) as	Tur	e to	er the mo	h Y	ng, such as cardia	or r	respiratory arrest,		Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Jue to (or as	a conseque	,		KW.	enti	a_		10. Am	
	d									
FEMALE: 23c. If yes, outcome pf pregnancy   23d. Date of delivery   1										
Part II. Other significant conditions	s contributing to death be	ıt not result	ting in the ur	nderlying	cause giv	en in Part I.			use cont	ribute to the cause of death?  3 ☐ Probably 4 ☐ Unknown
								24a. Was an autopsy		Were autopsy findings available prior to completion of cause of
								performed? 1☐ Yes 2☐		death? 1 ☐ Yes 2 ☐ No
25. Was case referred to cal examiner?					,	26. Place of De	áth (0	Check only one)		
1 Yes 2 10	Hospital: 1   Inpatie	nt 2∏E	R/Outpatien	t 3 🗆 🗈	Oth Oth	er: 4 Nursing I	Home	5 Residence	6 □Oth	ner (Specify)
27. Manuer of Death	28a. Date of Inju (Month, Da		28b. Time of Injury		28c. Injur Wor	y at k?	280	d. Describe how inj	jury occur	red

Physician/Medical in the past 9 Unknow Part II. Other sig Completed by 25. Was case ref examiner? Certification: To Be 1 Yes 27. Manner of De М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier ifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

ath (Item 23a) (Type, Print)

321 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7:15 PM /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Deatl Examiner tnna 100/13 7. Age (In yrs. last birthday) 85 Yrs. If Under 1 Year I If Under 24 Hrs. Date of Birth (Month, Day, **Funeral** 1 □ M 2 💢 F Director Usual Residence of Decedent with the Maryland 10a. State City, Town or Location 10d. Inside City Limits 28a-f show is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Medical Evaminar must be notified at 1 Yes 2 □ No Completed by Funeral Director urnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21060 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry decedents obtail occupation (Give kind of work done during most of working life. DO NOT use retired) IVCVAF+ WOVKEY Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည 19a Informant's Name/Belationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau alen 20a. Method of Disposition

12 Burial 2 ☐ Cremation 20b. Place of Disposition ceimetery, crematory Date 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Luneray Services Md. 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pheumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 5 Other (specify) 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 boten sion 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate I 1 ☐Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Nnpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 1 ☐Yes 2 ☐No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Strend Bak, Mo D46052 8/25/08 30. Name and address of person who completed cause of death (Item 23a), Type, Print) Panhway annapolis MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** homas 5:00 PM 4a. Facility Name (If not institution, give street and number)

Apt. 9 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 8343 Church Lane Apt. Baltimore Windsor Mill 5. Social Security Number 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Funeral 1**X** M 2□ F Months 217.62 172 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at Mill MID Baltimore Windsor Completed by Funeral Director 1 ☐Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8343 Church Lane Apt. 9 USA 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 No 3 Widowed 4 □ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Ma once. College (1-4or 5+) Elementary/Secondary (0-12) State of Manland 12th arade orvectional 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Jessie Deloach ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3107 Leighton Avenue Baltimone MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltmone, MD 09/03/08 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens Vallalin C. Greene Funeral SUC lan Randallstown MD 21133 Poad 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Immediate Cause (Final Cerebrovascular accident **Physician** disease or condition resulting in death) /Medical Examiner Sarcoidosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and requires that the death certificate be executed ue to (or as a con sequence of) Box 68760, attending physician for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a d be detached for 5 Other (specify) P.O. 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 done 1 ☐ Yes 2 📉 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has b page 2 sl 24a. Was an autopsy i Jell After this certificate funeral director, pag of Vital 1 ☐ Yes 2 X No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: ome 5 Residence 6 Other (Specify)
28d. Describe how injury occurred မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: Division To the Hospital or Attending 5 Pending investigation 1 Natural hours after death. uneral Director: A death. 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

AUG 2 6 2008

5400 31. Date filed (Month, Day, Year)

OUD

Randay 15 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(DUNI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2008 ar 12:20 A 2Ĭ Berena V. Reed August /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Towson Stella Maris Hospice Timonium 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 23, 1914 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 212-22-9616 1 M 2 X F Months Days Hours SC 94 Director Usual Residence of Decedent 10b. County 10a. State Show 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f shortraumatic event, the McJical Exprint months of traumatic event, the McJical Exprint or must be notified at Director MD Baltimore 1XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Aith 21213 1425 N. Ellwood Avenue Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: Black Completed by 1 ☐ Yes 200 No Specify. 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) unk Andrew Long ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Important: If Item 27 any injury or other tra George A. Foster / Nephew 2636 E. Oliver Street; Baltimore, Maryland 21213 20b. Place of Disposition (Name of cematery, crematory or other place)
Upper Hope Station Bpt.
Church Cemetery 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 08/27/2008 Fairfield Co., S.C. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, MD 21217 Farther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a y leading commodula cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-transit that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical attending for use as IF FEMALE: esn yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2XNo Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has bage ; autopsy certificate performed 1 □Yes 2 X No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 TOther (Specify) HOSPICE Hospital: 2 X No 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Registrar

State

29a. Certifier

DR.

31. Date filed (Mg

(Check only

29b. Signature and title of certifier

TARIQ MAHMOOD

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

DHMH 17 Rev 1/2001

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12:20 а.ш.

2008

21,

AUGUST

BERENA REED

2300 DULANEY VALLEY RD.

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TIMONIUM, MD 21093

29d, Date-signed (Month, Dav. Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

teven Rychwai	i	- For State Registrar	and / Department     Certificate	of Health and Mental of Death	Reg.	No. 200	8 2741
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last)  Steven S. Rychv	valski		2. Date of Death Month D August 20, 2	Day Year 2008	3. Time of Death 0950 hrs
		4a. Facility Name (if not institution, give street and n University Hospital		4b. City, Town, or Location of D		4c. County of Death	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 2		(MM/DD/YYYY) 9. Birth Foreign	
Director		215-13-1216 1XM 2 F	22	Yrs. Months Days Hours	Feb.12		
any		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc				10d. Inside City Limits
Maryland 28a-f show	٦	MD Baltimore	White	MArsh 10f. Zip Code	100	. Citizen of What Count	1 Yes 2 No
ith the Maryland 23a or 28a-f sho	Director	11013 Red Lion Roa	ıd	21162	109	USA	.,,
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f sho	uneral	1 X Never Married 2 Married Armed	Forces?	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Po		14. Race - Americ White, etc.	an Indian, Black,
after de	by Fu	3 Widowed 4 Divorced If Yes, Give You or Dates:		Yes 2 X No specify:		Specify: Who	
72 hours "natin		15. Decedent's Education (Specify only highest gradient Elementary/Secondary (0-12)  College	(1-4 or 5+) during	dent's Usual Occupation (Give king most of working life. DO NOT us		l6b. Kind of Business/In	dustry
5-0036 led within 72 hours at Hygiene. other than "natural the Medical Examin	ompleted	12th  17. Father's Name (First, Middle, Last)	Ele	ectrican	Name (First, Middle, Ma	Amtrak	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	Ignatius Rychwals	ski		ina Renne		
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental sant: If item 27 is marked or other traumatic event,	은	19a. Informant's Name/Relationship (Type, Print) Ignatius Rychwalski		iling Address (Street and Number 5739 Bessemor			- 1
		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal	20b. Place of Dis	position (Name of cemetery, rother place)		20c. Location - City or	
Baltimore, permit. Pages I at Department of Her Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licepsee	Garden	as of Faith  2. Name and Address of Facility	8/23/08	Rossvill	
Ba perm Depa Impe	, l	Cotuck R. Cerry		Connelly Fu	neral Hom	Ave. Bal	x 21221
Physician /Medical	8	23a. Part I. Enter the disease, or complications that failure. List only one cause on each line.		er the mode of dying, such as card	diac or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Ir	a consequence of):				
	Je.		a consequence of):				
hsit ed	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as	a consequence of):			7 3743	
executer an and al - trans		dd	)				
Box 68760, re death certificate be executed the attending physician and ed for use as the burial - transit	/Medical	3h Was decedent prognant in the	s, outcome of pregnancy			23d. Date of delivery	
Box 687: death certifice the attending ped for use as the	Physician/	past 12 months?	e birth 2 gnant at time of death 5	Fetal death 3 Ectopic p Other (Specify)	regnancy	Month D	Day Year
Records, P.O. Box The law requires that the death icate has been signed by the atte page 2 should be detached for u		1 Yes 2 No 9 Unknown 9 Unknown 9 Unk	nown to death but not resulting in th	ne underlying cause given in Part	I. 23e. Did tob	pacco use contribute to	the cause of death?
cords, P.O. law requires that the has been signed by 2 should be detach	ed by					2 ✔ No 3 Prob	
cord law req has bee	Completed				24a. Was ar autops perform	y prior to o ned? death?	topsy findings available completion of cause of
tal Rec rian: The l certificate l ector, page	Be Cor	25. Was case referred to medical		26.Place of Death (C	1 ✓ Yes 2 heck only one)	No 1 ✓ Ye	es 2 No
Division of Vital Records, ral or Attending Physician: The law requirers after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should the	To B	examiner? 1 V Yes 2 No Hospital: 1  27. Manner of Death 28a. Da	Inpatient 2 ER/Outpati			Residence 6 Other	<u> </u>
ion of tending Pheath.	ation:		of, 2008 0510 hrs		Struck by trail		
Divis al or At s after d al Direct ed in by	Certification:	3 Suicide 6 Could not be determined (Specific	ace of Injury - At home, farm, s	street, factory, office building, etc.	or Town, Sta		ral Route Number, City
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the b	est of my knowledge, death or	ocurred at the time, date and place	e, and due to the cause	e(s) and manner as state	ed.
To the within To the compl	Medical	one) 2 Medical Examiner: On the basi and manner 29b. Signature and title of certifier	s of examination and/or invest stated.	igation, in my opinion, death occu	irred at the time, date a	and place, and due to the 29d. Date signed (Mo	
		Patrian-Pol	loh m	O.C.M.E.		August 21, 2008	
10		30. Name and address of person who completed ca Patricia Aronica-Pollak MD. Assis		r 111 Penn Street, Balt	imore, MD 21201		
	tate	31. Date filed (Month, Day, Year)	Registrar's Signature	S.			
Regis	trar	MUCIA O 2000 ACA	ye D. God				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 Grace Denise August Renshaw 9:25 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Marley Neck Health & Rehab Glen Burnie Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 05 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Year) 1931 Months Days Hours Min. 1 M 2 X F 76 N.T Director 215-28-8974 Usual Residence of Decedent death with the Maryland 10a State show 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evanding to use the modified at Director 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 213 Phelps Avenue 21060 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. nd 2 should be filed within 72 hours after a alth and Mental Hygiene. 27 is marked other than "natural", or itel 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 TrNo Specify: þ White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Realestate Realtor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell Bavis Almeda Middleton ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar Department of Health Important: If Item 27 any injury or other trong. W. Carl Carlsen 213 Phelps Avenue, Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Aug. 26 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Lice, 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** areller touce disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) the 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an certificate has page 2 autopsy perform 2 **N**o 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2. No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∏ Yes After this Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation in 24 hours after the Funeral Director: After Funeral Director: After filled in by the fu 1 ☐ Yes 2 🗌 No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated. 29b. Signature and le of certifie 29c. License number 29d. Date signed (Month, Day, Year) D57023 35-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - TD-MD Chos #231 Annapolis 600 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 AUG 2 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5:00P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Service Service Birth Service Birt Samuatin MILLY 5. Social Security Number 7. Age (In yrs last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 💆 F Mary land 217-07-0917 93 **Director** Usual Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Evantinar must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Md. Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 409 Virginia Avenue Apt 205 21286 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. Š Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Office Manager G.C. Murphy Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Rolfes Mary Jagielski မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1808 Bear Creek Drive Forest Hill, Md.21050 JoAnn Gayo (niece) 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary Cem 8-26-2008 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Raczorowski Funeral Home, PA 21. Signature of Funeral Service Lice see 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are ach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Quelto for as a consequence offior Attending Physician: The law requires that the death certificate be exacuted attending physician and for use as the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 🗆 Ectopic pregnancy Month Year Day 5 Other (specify) certificate has been signed by the irrector, page 2 should be detached 1 ☐ Yes 2√ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes P□No 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Beath Watural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Tyes 2 🗆 No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Hospital Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier use of death (Item 23a) (Type, Print) 152015010 105016E CI Date Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** JEMINS 200 8 /Medical MIA 2/ 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner : Kg OSh 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 □ F 212-09-1245 Yrs. FEB. 2, 1920 VIRBINIA Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland reent of Health and Mental Hygiene. and the than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show than the the transite event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No CATONSVILLE BALTIMORE Director MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 401 SHADETREE PL., Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK à 3 ☐ Widowed 4 ☐ Divorced 2-7-1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. POST OFFICE HANDLER MAIL GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be STEWART S*EZEBE*L ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) YOI SHADETREE PL., APT.C., CATONSVILLE, MD 21228 ELIZABETH O. STEWART (WIFE) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ■ Burial 2 □ Cremation 3 □ Removal from State GARRISON FOREST CEM. 08-28-2008 DWINGS MILLS, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility

22. Name and Address of Facility

30SEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE, BALTIMORE, MD 21217 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Jue to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-transit and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0. detached 9☐Unknown 9 Unknown ģ been signed the should be detailed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 1 Yes 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' certificate 1□ Yes 212 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA မ this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1 10 rthwest Spila

State Registr<u>ar</u> 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1255 DM STEWARZ RANGIS 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner BALTO RANDAILSTOWN N.W. HOSDITAL Date of Birth (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Country) Md. 1 M 2□ F 212-20-3320 Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at BALTO. 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò SEGOVIA 21215 (1.5A 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Deves 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items, 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes þ 2 No Specify 3 ☐ Widowed 4 ▶ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) AIN eR 12 th 17. Father's Name (First, Middle, Last) Be Department of Health and Mental I Important: If item 27 is marked of any Injury or other traumatic ever JAMES ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Pages 1 and 2 2637 JACQuelin 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 23a. Part 1. Enter the diseas Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Myscardial
Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed and burial-Due to (or as a consequence of) physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate the as 1 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Į in the past 12 months? Month Day Year 5 Other (specify) P.0. 1 □Yes 2 □No 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? Division of Vital 1 ☐ Yes 1 ☐Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) SMSON Hospital: Other: 4 Nursing Home 5 Residence 1 Tes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 6 Other (Specify) funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 T Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

STREET RESTORSTOWN MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM# 24a, b, perPHYS., G882, 8/26/08, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Louis M. Schroeder 9:00P M 8-12-2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Balto. Stella Maris Hospice Timonium 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. **№** М 2 П F Director 1-13-1931 213-26-8816 Md. Usual Residence of Decedent 10a, State 10h. County 10c. City, Town or Location 10d Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: if item 23a or 28a-f shov important: if item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at Director Baldwin 1 ∐Yes 2\no Balto. Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21013 6403 Baldwin Gate Rd. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 📆 Married 1 ☐ Yes 2 🟋 No Specify: White ð Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Eastern Stainless Steel <u> Assistant Chief Inspector</u> Pages 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ George Schroeder Elizabeth Kaminski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6403 Baldwin Gate Rd. Baldwin, Md. 21013 Wife Eloise Schroeder 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town State 1 🖫 Burial 2 ☐ Cremation 3 Removal from State 3-16-2008 4 Donation 5 Dother (Specify) St. John's Hydes Hydes 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** LUNG- CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) physician the attending as use IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year Day 5 Other (specify) 1 □ Yes 2 □ No. detached 9 Unknown p s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate Yes ueatin? 1 □Yes 2 No or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$ Other (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A 1 □Yes 2 □No filled in by the 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completely (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2

10

9:00 р.ш.

12, 2008

AUGUST

Baltimore, Maryland 21215-0036

Vital Records, P.O. Box 68760,

of

Division

LOUIS SCHROEDER

State Registrar DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

2300 DULANEY VALLEY RD.

AUG 2 6 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

**ORIGINAL** 

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month AMONTH 2:50 AM Obelo 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Linthicum Anne Arundel The Tate House 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 74 216-30-5448 02-19-1934 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Anne Arundel Odenton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21113 United States 8605 Wandering Fox Trail Apt. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 N Married 1 ☐ Yes 2 🖔 No Specify 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) 4 Electrical Engineer Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) August Selig Magdalin Fiedler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8605 Wandering Fox Trail Apt. Katherine Selig / Wife 305 Odenton, MD 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 8-25-2008 Baltimore, Maryland re of Funeral Se 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A M01522 1411 Annapolis Road Odenton, Maryland 21113 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a cons-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy dent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 12 months? 2 ☐ No 5 Other (specify) 9 Unknown gnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes 6 Other (Specify)

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, the

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

10a. State

MD

Director

Funeral

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Completed

Be ဥ

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Exami edical

Division of Vital Records, P.O. Box 68760

nysician/IM	IF FEMALE: 23b. Was deceded in the past 1 ☐ Yes 9 ☐ Unknot
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TE OS	
o pe	25. Was case re examiner? 1 ☐ Yes 2
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Medical

							_ ()	1 ☐ Yes 2 [	] No 3 ☐ Probab	ly 4 Unki	
							_	24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy prior to comp death?		
25. Was case referred	to medical					26. Place o	f Death (0	Check only one)			
examiner? 1 ☐ Yes 2 ☑ No	2 No		1 ☐ Inpatient 2 [	BR/Outpatient	3 🗆	DOA Other: 4 Nurs	ing Home	5 Residence	Other (Specify)	Hesple	
2 Accident	5 ☐ Pending investigation	(	Date of Injury (Month, Day, Year)	28b. Time of Injury	M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No		8d. Describe how injury occurred			
3 ☐ Suicide € 4 ☐ Homicide	Could not be determined	28e. P	Place of Injury - At I puilding, etc. (Spec	nome, farm, stree	t, facto	28f	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1 [ (Check only 2 [ one)	Certifying Ph Medical Exam	niner: On t	o the best of my kr the basis of examir manner stated.	nowledge, death on ation and/or inve	occurre stigati	ed at the time, date and on, in my opinion, death	place, an	d due to the cause(s) at the time, date and	and manner as stat place, and due to th	ed. e cause(s)	
29b. Signature and hile	of certifier				2	9c. License number		29d. Dat	e signed (Month, Da	y, Year)	

State Registrar 31. Date filed (Month, Day, Year AUG 26 2008

30. Name and address of person who completed cause

32. Registrar's Signature

			1 _ State	ate of Maryland /	-	rtment of H tificate of L			2000	27121	
			Registrar  1. Decedent's Name (First, Middle, Last)		Cei	incate of t	Jeaur		Reg. No. 2 U U 8		
	Physici		Mary Stotler					Month August	t 21, 2008 10:20 A		
	/Medio		4a. Facility Name (If not institution, give street	and number)	T	4b. City, Town, or	Location of Death	8	4c. County of Death	1 - 3 - 3 - 3	
			1418 Cambium Ct.				nover		Anne Ar		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last I	birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthi		
	Director		460-22-3837 Usual Residence of Decedent	86				03-06-19	922   1	exas	
	ryland <b>how</b>	_	10a. State 10b. County	10c. City, To	wn or Loc	ation			1	0d. Inside City Limits	
	Ba-f s	Director	MD Anne Arund	le1			over			1 □Yes 2X No	
	with the		10e. Street and Number			10f. Zip Code		10	Og. Citizen of What Cour	•	
	should be filed within 72 hours after death with the Maryland mid Mental Hyglene. In marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show umatic event, I'm invidical Evaluation intelligible at	by Funeral	1418 Cambium Ct.	/as Decedent Ever in U.S.	13. W	-	1076 ispanic Origin? (Sp	ecify Yes or No-	United St		
9	after d	Fur	A 1 □ Never Married 2 □ Married 1	rmed Forces? ∐Yes 2X No	lf.	Yes, specify Cuba <b>X</b> Yes 2□No	ın, Mexican, Puerto	Rican, etc.)	Black, White,		
21215-0036	ours a	d by	3X Widowed 4 □ Divorced Y	Yes, Give ear or Dates:	1	OLYes 2∐No	Specify: Mexi	can	Specify: Mex	xican	
2	"natu	Completed	15. Decedent's Education (Specify only highest grade corr	n 16 npleted)	Sa. Deced	ent's Usual Occupa aind of work done of	ation Juring most of worki I)	ing 1	6b. Kind of Business/In	dustry	
12	withir lene. • than	omp	Elementary/Secondary (0-12) C	ollege (1-4or 5+)		ome Make:			Own Home	<b>,</b>	
פַ	e filed al Hyg other /ent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M			
/lar	uld be Menta arked atic ev	To E	Ildefonso Zambran	0			Franc	isca Seg	ura		
Maryland	2 sho and is me		19a. Informant's Name/Relationship (Type. P	· ·		,			City or Town, State, Zip	Code)	
o, o	l and Health Hm 27 Her ti		Cynthia Mitzman / Da						1and 21076	- Chata	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. I more activities a state of Health and Health and Health and Health and Health and Indicate I for it is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Mydical Eval. Find in the Indicate and Once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove	al from State	-	ition (Name of atory or other plac	i		•	•	
	nit. Pa artme ortani injury		4 □ Donation 5 □ Other (Specify)  21. Signeture of Funeral Service Licensee	Glen	22	Namo and Address	ark   08-26		Glen Burnie	•	
ñ	any per	9.4	PHINO 2 DO MG	X 110 M01522	$\begin{bmatrix} & & D \\ 2 & & 1 \end{bmatrix}$	onaldson 411 Anna	Funeral	Home & C	Crematory, l on, Maryland	2.A. 1 21113	
Г			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call	ne that caused the death. D						Approximate Interval Between	
F	hysician		Immediate Cause (Final disease or condition	AL	Z.h	Pime	S 1	trem	5	Onset and Death	
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	Lammer	<u>.</u>	Sequentially list conditions, b. —	Due to (or as a consequenc	e sille						
	nsit	mine	Sequentially list conditions, if any, leading to immodule cause. Enter Underlying Cause (Disease or injury	Dee to (or as a consequenc	e oi).						
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58/60,	icate be executed physician and the burial-transit	edical	d								
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Š RO	death certific e attending p d for use as	Physician/Me	23b. Was decedent pregnant 23c. If	yes, outcome of pregnancy Live birth 2 Fetal dea		Ectopic pregnancy	/		23d. Date of deliv Month	ery Day Year	
5	the de	ysic		☐ Pregnant at time of death ☐ Unknown	5 🗆	Other (specify)					
7.	w requires that the de been signed by the should be detached		Part II. Other significant conditions contribute	ting to death but not resulting	j in the un	derlying cause give	en in Part I.	23e. Did tob	acco use contribute to t	he cause of death?	
ecords,	requires seen sign nould be	ed by						1 □ Ye	s 2 ☐ No 3 ☐ Pro	bably 4 Unknown	
၀ ပ	law re as bec 2 shor	ompleted						24a. Was an		ppsy findings available	
ב ו	The ate h	Com						autopsy perform 1 □ Yes 2	ed? death?	mpletion of cause of 2 □ No	
VITal	nding Pnysician: The law th. : After this certificate has b s funeral director, page 2 s	Be (	25. Was case referred to medical examiner?				26. Place of Death		/		
_	요 물 말	2	1 Yes 2 No Hospit	1   Inpatient 2   ER/0	Outpatient		4 🗆 Nursing Ho		nce 6 Other (Speci	(y)	
פח	ding h. After funer	ertification:	1 Natural 5 ☐ Pending	(Month, Day, Year)	Injury	28c. Injury Work	yat {? Yes 2 □No	28d. Déscribe ho	w injury occurred		
UNISION	Atten	ifica	e □ could not be	e. Place of Injury - At home, building, etc. (Specify)	farm, stre			28f. Location (Str	reet and Number or Run	al Route Number,	
5	s after s after all Director	Cert	4 Homicide determined	building, etc. (Specify)				City or Town	, State)		
	To the Hospital of Attending Privals after death.  To the Funeral Director: After t completely filled in by the funera	Medical (	(Check only 2 Medical Examiner:	n: To the best of my knowled On the basis of examination and manner stated.	lge, death and/or inv	occurred at the tine stigation, in my o	ne, date and place, pinion, death occur	and due to the cared at the time, da	ause(s) and manner as a ate and place, and due t	stated. o the cause(s)	
4	Nithin No the Somple	Mec	29b. Signature and title certifier	manner stated.		29c. License	e number	29	9d. Date signed (Month,	Day, Year)	
	X		) Det	$\gamma$		Di	11927		8-77-	- b 8	
	17)		30. Name and address of person who comple	ted cause of death (Item 23a	a) (Type, F	rint)	11/1/	D) (	2. 1	. 0 61	
	10		Josup Mels	3-414VD		FUX W	protovo	KO 1	aladone	MO WILL	
	Sta Registr		31. Date filed (Month, Vay, Year)  AUG 2 6 2008	Registrar's Signature	Lan	A 19					
DHM	IH 17 Rev 1/20		MUU & 0 2000	AND THE PROPERTY OF	AST ASSA						

08-06441 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene LaQita Saunders 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day August 22, 2008 1930 hrs Medical Examiner Maria 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) 3207 Brightwood Avenue Gwynn Oak 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** Foreign Months Days Hours Min Director Country) M 2 XF Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Baltimore is 23a or 28a-f show e notified at once. Yes 2 28a-f show MID Director 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country' Brightwood 3207 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S Important: If item 27 is marked other than "natural", or items injury or other tranmatic event, the Medical Examine<u>r must be</u> Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. after death 1 Never Married 2 Yes 14ack Yes 2 X No specify. Specify Divorced If Yes, Give Year ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) more, MD 21215-0036
Pages 1 and 2 should be filed within 72 least of Health and Mental Hygiene. U.S. Government arade ears (First, Middle, Maiden Sumame) Be ande 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) A ande tvenue Balto. MD Brightwood Saunders 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place Burial 2 Cremation 3 Removal from State Noodlawn Other Specify Donation 5 Signature of Funeral Service Licenses Kandalktown MD 21133 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Between Onset and only one cause on each line /Medical Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit Hospital or Attending Physician: The law requires that the death certificate be executed hysician/Medical 1 per me g883 9-9-08 vt 27 per me g884 10-20-08 X UNPENDED ned by the attending physician detached for use as the burial 27 per me g884 10-17-08 vt Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregna 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Dav Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✓ Unknown g Unknown 굽 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 ✓ No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available been 24a. Was an autopsy prior to completion of cause of has performed' death? certificate ✓ Yes 2 1 🗸 25. Was case referred to medical 26 Place of Death (Check only one) director, Be Other<sub>4</sub> examiner? Hospital: DOA Residence 6 V Other: Scene 1 ✓ Yes Inpatient 2 ER/Outpatient 3 Nursing Home 5 After this ဥ funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Pending Yes 2 death. filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide

To the Funeral Director:

29a. Certifier

29b. Signature and title of certifier

Margarita Korell MD. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

2008

Assistant Medical Examiner

32. Registrar's Signature

ical

DHMH 17 Rev 1/2001 OCME 2006

Registra

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

August 23, 2008

				Please							Ensure /	-		-	2 0	71.00
			For State Registrar		State	of Ma	ryland		artme <i>rtifica</i>		lealth and Death	Mental Hy	/giene Reg. No		3 2	27423
			1. Decedent's Nam	ne (First, Middle, L	ast)							2. Date of D	eath		3. T	ime of Death
	Physicia /Medic		Dorot	hy Ann	Spech	а						Month Augus	Da t 25		1	:35 P <sup>M</sup>
	Examin		4a. Facility Name (	'If not institution, g	ive street and n			4b. City	, Town, o	Location of Dea	th	4c.	County of Dea	th		
			Ridgewa	-							ille			altimo		
	Funeral		5. Social Security N 349-12-		Sex 1 □ M 2 <b>X</b> 2 F		(In yrs. k	a <i>st birthd</i> ay Yrs.	Months	r 1 Year Days	If Under 24 Hrs Hours Min	. (Month, D	lay, Year)	C	ountry)	State or Foreign
	Director		Usual Residence of									MAR 1	8, I	921 11	linc	)1S
	yland how		10a. State	10b. County			10c. City	, Town or L	ocation						10d. Ins	side City Limits
	a-fs	Director	MD	Baltim	ore		Catonsville								1 [	∐Yes 2∭ No
	or 28	Dire	10e. Street and Nu	ımber					10f. Z	ip Code			10g. Ci	tizen of What C	ountry?	
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	er de	Funeral	11. Marital Status	ried 2□ Married	12. Was De	Forces?		S.   13	. Was Dec If Yes, sp	edent of Fecify Cuba	lispanic Origin? (: an, Mexican, Puer	Specify Yes or N rto Rican, etc.)	specify Yes or No- to Rican, etc.) 14. Race - An Black, Wh			ian,
2000	irs aff	þ		er Married 2 ☐ Married 1 ☐ Yes 2 ※ N If Yes, Give owed 4 ☐ Divorced Year or Dates:					1 □Yes	1 □Yes 2 No Specify:				Specify: White		
5	2 hou	ted	(0	15. Decedent's I					edent's Us				16b. K	ind of Business		
7	should be filed within 72 hours after death with the Maryland and Mertal Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the model Even the cust be notified a	Completed	Elementary/Seco			(1-4or 5+	)	life.	DO NOT	use retired	7	orking				
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	hould nd Me mark matic	욘	19a. Informant's N		(Time Print)		-	10h Mai	lina Addros	s (Street	Mitha and Number or F		her City	or Town State	Zin Code	1
	alth ar 27 is r trau		John A.								Rd Ca					
<u>5</u>	s 1 and 2 of Health item 27 i		20a. Method of Dis	•			20b. Pl	ace of Disp emetery, cr	position (Na	ame of	201	Date	20c. L	ocation - City o	Town, St	ate
	Pages nent of I ant: If ite ury or of		4 Donation	Cremation 3 5 ☐ Other (Spec	ify)	m State	1.	ro Cr				9/08	Balt	imore,	MD	
Daltamor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminer must be multilised an once.															
_	70 E 8 9		301 Frederick Rd Catonsville, MD 212													
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ń	res tha	þ	Part II. Other signi	ificant conditions	contributing to	death but	t not resu	Iting in the	underlying	cause giv	en in Part I.			use contribute		
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Ĕ	or Atter de lirecte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	be d 28e. Pla bui	ice of Injur ilding, etc.	ry - At ho (Specify	me, farm, s	treet, facto	ry, office			(Street a	nd Number or I e)	Rural Roul	te Number,
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only one)	2☐ Medical Ex	aminer: On the	e basis of anner stat	examina	tion and/or	investigation	on, in my	me, date and place opinion, death occ	ce, and due to the curred at the time	e, date an	s) and manner id place, and di	as stated. le to the c	ause(s)
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	Sta	to	Charles 31. Date filed (Mor	nthe Day Year)	IM 100	nistra	r's Signat		ints	HVE	-, BAL	To, MS	) 2	1127	7	
	Registr			HUG 2 6	2008	Logica	ار م	K	best							

DHMH 17 Rev 1/2001

Registrar

BEL AIR, MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

AUG 2 6 2008

615 WEST MACPHAIL ROAD

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 09:51 AM Norene Elizabeth Sheeler 449 2008 28 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Saint Agnes Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) March 7,1922 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 218-12-4054 86 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director 1 X Yes 2 □ No Maryland Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1228 Pine Heights Avenue 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify Specify: Completed by 3K Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home s 1 and 2 should be filed v f Health and Mental Hygie Item 27 Is marked other t other traumatic event, th other i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nelson George Kroner, Jr. Norene Mary Sullivan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr Francis Sheeler 771 Juli Drive; New Freedom, PA 17349 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 8/26/2008 Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Livery 1630 Edmondson Avenue; Catonsville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** Preymonia /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be execute burial-trar Due to (or as a consequence of): Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1□ Yes Division or Vital Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 Yes 2 No n 24 hours after death.

The Funeral Director: A pletely filled in by the fi death. 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one) and manner stated. To the within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AS24385284106 10 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Caton Ave Baltimore MD 21229 000209 icholas lou 00 32 Registrar's Signature 31. Date filed (Month) Bay Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Evelyn E. Siegmund August 20, 2008 7:00 /Medical Α. 4a. Facility Name (If not institution, give street and number)
Shannon Building
2525 Pot Spring Rd. 507 S 4b. City, Town, or Location of Death 4c. County of Death Examiner Timonium Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M & 🔀 F 95 Yrs 212-05-5044 Director July 1, 1913 Balt., Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at Maryland Baltimore Director Timonium 1 ☐ Yes 2 ☑ No 10e. Street and Number Shannon Building 10f. Zip Code 21093 10g Citizen of What Country? 2525 Pot Spring Road 507 S 21853 of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Completed by Specify: white 3₺ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Department of Human Resources marked other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Fred Engle Department of Health and Men Important: If item 27 is marke any injury or other traumatic 2 Eva Walters Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)21853 Health a tem 27 is David White/ nephew 10191 Crab Island Road Princess Anne, Maryland Baltimore, 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State August 23, Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 Bel Air 21. Signatur Fun ral Service Licensee 22. Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ONGOCTI /Medical Due to or as a con sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4 Pregnant at time of death 5 Other (specify) P.0. detached 9 ☐ Unknown 9 ☐ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ funeral director, page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Vital 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5. Residence 6 ☐ Other (Specify) of Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending Division 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **completely** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 2300 DULANEY VALLEY ROAD ERNESTINE WRIGHT, M.D. TIMONIUM MD21093

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

:00

2008

AUGUST

WEDNESDAY

SIEGMUNL

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32 Registrar's Signature

Amend #1, perMD G882 8/28/08 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Dora May, Schmidt 2. Date of Death Dav Month **Physician** Year 2/ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MD HOSPITAL HESTERTOWN If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) (State or Foreign **Funeral** Days Months 1 M 2 ₩ F 214-12-2070 87 Director MD April 26 1921 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 ☐ No Directo Maryland Queen Anne Ingleside 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 2260 Goldsboro Road 21644 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2☐ No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White þ Specify: 3 ₩ Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Household 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be C. John Grempler Lillian ٩ Merson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maxine Salyers (daughter) 2260 Goldsboro Road, Ingleside, MD 21644 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Aug. Metro Crematory Inc 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 2008 21. Signatule of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, 3111 Mountain Road, Pasadena, MD 21122 rant. Enter the sease, or o shock, or heart fail re. List o 23a, Parl 1, Enter the Approximate Interval Between Onset and Death is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ise on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine aw requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the sahould be detached 1 Yes 2 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate iou 1□ Yes 2 No e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifica 25. Was case referred to medical examiner? filled in by the funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1<sup>™</sup>Natural 5 Pending investigation Injury 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 G-certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Monte 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 AUG 2 6 Registrar

DHMH 17 Rev 1/2001

08-06	420
Virgil	Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Certifical Registrar	te of De	eath		F	Reg. No.	200	0 6146
Physicia	an/	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month Day Year							
ledical Exami	ner	Virgil Smith				August 2	2, 2008 4c. Coun	0940 hrs	
		Facility Name (if not institution, give street and number)     South Collington Avenue		City, Town, or L altimore	ocation of L	Jean	4¢. Court	ty or Death	
Funeral		Social Security Number		Under 1 Year	If Under 2	4Hrs. 8. Date of B	irth(MM/DD/YY	YY) 9. Birth	place (State or
Director		218-70-0003   1X M 2 F   37	Foreigr Cou	ntryMaryland					
		Usual Residence of Decedent	Yrs.		l	12/10	3/ <u>1970</u>		
any		10a. State 10b. County 10c. City, Town or	Location						10d. Inside City Limits
Aaryland 28a-f show 1 at once	5	Maryland N/A Baltimo	re						1 X Yes 2 No
in the Maryland	Director	10e. Street and Number			10g. Citizen of	What Coun	try?		
th the 23a or	اق	223 S. Collington Avenue		21231			United		
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	uneral	1 X Never Married 2 Married Armed Forces?				? ( Specify Yes or Nuerto Rican, etc.)		hite, etc.	can Indian, Black,
ter de	ᄣᆝ	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes	s 2 <b>y</b> No	specify:		Specif	fy: Wh:	ite
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5 72 hc nn "ns	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	iring most o	of working life.	DO NOT us	e retired)			
5-0036 led within 72 Hygiene. other than '	Complet		rpente				Carpe		
filed if Hyging of oth	ပို	17. Father's Name (First, Middle, Last)		1		Name (First, Middle		me)	
2121 2121 Juld be fi Mental marked ic event,	To B	John Lawrence Smith, Sr.  19a. Informant's Name/Relationship (Type, Print)  19b.	Mailing Add			hy Mae Da er or Rural Route No		Fown, State,	Zip Code)
nore, MD 2121 ages I and 2 should be fi fire of Health and Mental tt: If item 27 is marked other traumatic event,		Dorothy Mae Smith - Mother 22	3 S.	Colling	aton A	venue Ba	ltimore	. Mary	yland 21231
e, e, l and l and Healt litem		20a. Method of Disposition 20b. Place of		(Name of cerr		Date	20c. Locatio		
Pages ent of nt: 11		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:				8/26/2008	Balti	more,	Maryland
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		21 Signature of Funeral Service Licensee				uneral H			1
<b>™</b> 59 7 1 1	0	Junio Kt	1401	S. Ches	ster S	Street Ba	ltimore	. Mary	yland 21231
Physician / Medical	7	23. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.	enter the m	node of dying, s	such as car	diac or respiratory a	rrest, shock, or	heart	Approximate Interval Between Onset and
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OX 68 eath certifi attending for use as	sician/	past 12 months?  1 Live birth 2 4 Pregnant at time of death 5	Fetal d	leath 3 (Specify)	Ectopic p	regnancy	Monti	n L	Day Year
Box (e death or the attended for use	hysi	1 Yes 2 No 9 Unknown g Unknown	Other	(Opcony)					
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Division spital or Attendir ours after death, erral Director: A	Certification:	Suicide X Could not be determined (Specific) House	iii, sueet, ia	actory, office bi	unung, etc.	or Town	State 221	S. Co	llington Av
Hospi 24 hou Funer ely fil		4 Homicide  29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	th occurred	at the time, da	te and plac				
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ledical	one) 2 Medical Examiner:On the basis of examination and/or in and manner stated.	vestigation,	in my opinion,	death occu	rred at the time, da	te and place, ar	nd due to th	e cause(s)
E 3 E 8	Me	29b. Signature and title of certifier		29c. License	e number		29d. Date s	signed (Mo	nth, Day, Year)
		Wongone The While		O.C.N	И.Е.		August :	23, 2008	
10		30. Name and address of person who completed cause of death (Item 23a)		0		MD 0400:			
				n Street, Ba	altimore,	MD 21201			
S	tate	31. Date filed (Martin Day, Year) 2008 Registrar's Signature	13000	gr/					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** August 20, 2008 11:55р м Allan Shoemaker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Year Months Days Hours M 2 □ F 212-28-8071 75 October 10, 1932 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Wedical Evant har must be notified at 1 ☐ Yes 2 No Randallstown Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 United States Funeral 9057 Meadowheights Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after My Yes 2 No If Yes, Give Korean Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail Food Sea Food Manager i. Pages 1 and 2 should be filled wi tment of Health and Mental Hygier tant: If Item 27 is marked other th ijury or other traumatic event, the 7th. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank H. Shoemaker Evelyn Gillespie 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 9057 Meadowheights Road, Randallstown, MD 21133 Concetta Shoemaker 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Buria! 2 X Cremation 3 ☐ Removal from State permit. Page Department or Important: If any injury or Atlantic Crematory August 22, 2008 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 21. Signature of Funeral Service Licenses 8728 Liberty Road, Randallstown, MD 21133 1400333 Enci Partyl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Immediate Cause (Final disease or condition resulting in death) **Physician** 1 ver CANCER mouth /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760physician Physician/Medical the attending asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 D Unknown 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 🗀 Yes Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy 2 No 1 ☐ Yes 2 No 1 ☐ Yes or Attending Physician: director, Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 1100 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours a Hospital ca 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the To the within 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balto My Zczak V. Churles St. 2. Registrar's Signature Date filed (Month, Dav. Year) State AUG 2 6 2008 Registrar

Shoemaker

			For State Registrar	State of	Marylar	nd / Depa	artmen rtificate	t of H	ealth a	and M	lental Hy	giene (	8 (	27430	
	Physici		1. Decedent's Name (First, Midd Sherman	lle, Last)		Ste	unb	erq			2. Date of De Month	Day 23	Year 2008	3. Time of Death 10:57 A M	
	/Medic Examir		4a. Facility Name (If not institution	nber)		4b. City,	Town, or	Location of				ty of Death	1		
			University of Ma	aryland Me	edical (	Center			nore			N/	A		
	Funeral Director		5. Social Security Number 218-01-1137  Usual Residence of Decedent	6. Sex 1 M 2 □ F	7. Age (In yrs. 8		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi Month D 02/15/	1921	9. Birth	place (State or Foreign intry)	
	aryland show	_	10a. State 10b. County	, I/A	10c. Cit	ty, Town or Lo	cation IMORE							10d. Inside City Limits 1 X Yes 2 □ No	
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Baltimore,	les 1 ar of Hea of Hea of Item 3		20a. Method of Disposition 1 Ø Burial 2 ☐ Cremation	•	20b F	Place of Dispo	sition /Nan	ne of		C	Date	20c. Location	- City or T	own, State	
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Ba	Depa Impo any it		21. Signature of Funeral Service	i'us —			8900	REIS	TERS	FOWN	ROAD -			, INC. , MD 21208	
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun	Medical	29a. Certifier 1 Certifying (Check only one)	ng Physician: To the Examiner: On the ba and mann	sis of examina	owledge, death tion and/or in	occurred a vestigation,	at the tim in my op	e, date an	d place, th occurr	and due to the ed at the time,	cause(s) and n date and place	nanner as , and due	stated. to the cause(s)	
	Veith To t	Σ	29b. Signature and title of certifie	er MD					number	-		29d. Date sign		, Day, Year)	
			· year					1-21	195			8/23	108		
	10		30. Name and address of person	20 /			Print)  Himo	e	MN	212	01				
	Sta Registr		31. Date filed (Month, Day, Year AUG 2 6 20	32. Re	ogistrar's Signa	ature	فري			V					

			For State Registrar	State of I	Maryland / De	partment of ertificate of		and Mental H	ygiene	008	27431	
			Decedent's Name (First, Middle, L.)	ast)			-	2. Date of D	eath Day	Year	3. Time of Death	
	Physicia		Helen Clara Sti	ckle				August		2008	1:00 P M	
	/Medic Examin		4a. Facility Name (If not institution, ga		er)	4b. City, Town,	or Location o	f Death	4c. Co	4c. County of Death		
	Zxami	٠.	Broadmead Nursi	ng Home		Hunt Va	alley		Ba	ltimore		
	Funeral		5. Social Security Number 6.		Age (In yrs. last birthd	Months   Davis		Min. (Month, L	Day, Year)	Cou		
	Director		285-16-3223	1□M 2 <b>X</b> )F	93 Yrs			May 2	1, 191	5	Ohio	
	pur *	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	Location					10d. Inside City Limits	
	sho	ō									1 ☐ Yes 2 🎇 No	
	the N	ect	MD Baltimo	re	Hunt Va	10f. Zip Code			10g. Citizer	n of What Cou	ntry?	
	with ta or	Ö				21030			USA			
	atter death with the Marylan or Itama 23a or 28e-f show increment be notified at	Funeral Director	13801 York Road	12. Was Decede	ent Ever in U.S.		Hispanic Ori	gin? (Specify Yes or N , Puerto Rican, etc.)		Race - Ameri		
(0	ritar	핖	1 ☐ Never Married 2 ☐ Married	Armed Force	es? □ <b>X</b> No			i, Puerto Hican, etc.)		Black, White,	, etc.	
93	ral', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Date		1 ☐ Yes 2 🔀 No	Specify:		50	pecify:	vhite	
5-0	72 hc	Completed	15. Decedent's (Specify only highest g		(6	ecedent's Usual Occi	e durina mosi	t of working	16b. Kind	of Business/Ir	ndustry	
2		mpi	Elementary/Secondary (0-12)	College (1-4	or 5+)	e. DO NOT use retir	ed)		0	11		
2	led w lygier har tl		17. Father's Name (First, Middle, Las	4	Hom	emaker	18 Mothe	er's Name (First, Midd		Home	··	
Maryland 21215-0036	12 should be filed within "h and Mental Hygiene. 7 Is marked other than "r	Be						ra Kennedy	.0,			
Ž	d Me d Me mark matic	ပ္	Holley G. Wellman 19a. Informant's Name/Relationship		19b. M	ailing Address (Stree		er or Rural Route Num	ber, City or T	own, State, Zi	p Code)	
Ma	d2s th an t7 is		Gary R. Bozel	/ PR				nue Suite				
	es 1 and 2 should be filed within of Health and Mental Hygiene. It item 27 Is marked other than r other traumatic avant, If a M		20a. Method of Disposition	7 110	20b. Place of D	sposition (Name of crematory or other pi		Date		tion - City or T		
Baltimore,	9 = 5		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		ate	Service	.	8/23/08	Tows	on, MD		
Ħ	permit. Pag Department Important: any injury o	1	21. Signature of Funeral Service Lic		MITICOD	22. Name and Add			SPICE ASSESSMENT	50 York	Road	
ä	permit. Departr Importa any inja		* KIT			Ruck Tow	son Fu	neral Home			MD 21204	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cau	sed the death. Do not						Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition		1-5/	V DI	mi	ntia			Onset and Death	
	/Medical		resulting in death)	Due to (or	as a consequence of)			7				
	Examiner		Sequentially list conditions,	b								
	ם ב	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence of)							
	and and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	as a consequence of)							
8760,	ate be executed hysician and the burial-transit	<u>E</u>	Toolking in accus, sact	Due to (or	as a consequence or,							
87	ate hys	dical		d		<del> </del>						
9 X	The law requires that the death certific the has been signed by the attending p tage 2 should be detached for use as:	by Physician/Me	IF FEMALE:	23c. If yes, outco	ome of pregnancy				236	d. Date of deliv	verv	
Box	atten I for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt	h 2 Fetal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)	icy		_	Month	Day Year	
Ö	t the de by the	ysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknow	vn				-			
σ,	s that ned b	y P	Part II. Other significant conditions	contributing to dea	th but not resulting in t	ne underlying cause (	given in Part I	l. 23e. Di	d tobacco use	contribute to	the cause of death?	
rds	requires een sign nould be		Hypull	nsion				1[	∐Yes 2 🗗	No 3□Pro	bably 4 Unknown	
Vital Records,	aw requ s been 2 shoul	Completed	Ischemic	Hon	4 DIS	1051/		24a. W	as an itopsy	24b. Were au	topsy findings available completion of cause of	
R	The lav	E O						pe 1 □ Yes	rformed?	death? 1 ☐ Yes	<u> </u>	
ital		Be C	25. Was case referred to medical examiner?				26. Place	e of Death (Check on	ly one)			
	Attanding Physiclan: r death. sctor: After this certificator in the funeral director.	일	1 □ Yes 2 □ No		patient 2 ER/Outp	atient 3 DOA		ursing Home 5 Re			cify)	
0	Jing Pl		27. Manne 1 Death 1 Leatural 5 Pending	28a. Date of (Month,	Injury 28b. Tin Day Year) Inju	iry W			e how injury	occurred		
Sio	Attandi death. ctor: A y the fu	cati	2 Accident investigat 3 Suicide 6 Could not				Yes 2		- /Street and	Number of Di	ıral Route Number,	
Division of	or Attano after deatl Diractor:	Certification:	4 Homicide determine	ed 28e. Place o	f Injury - At home, farm g, etc. (Specify)	, street, factory, offic	e		Town, State)	VUILID BI OI HU	rar Noble Number,	
	pital		29a. Certifier 1 Certifying	Physician: To the h	est of my knowledge,	feath occurred at the	time date a	nd place, and due to t	he cause(s) a	nd manner as	stated.	
	24 h	edicai	(Check only 2 Medical Ex	aminer: On the bas	is of examination and/	or investigation, in m	y opinion, dea	ath occurred at the tim	ne, date and p	lace, and due	to the cause(s)	
	To tha Hospital or Al within 24 hours after of To the Funarel Dirac completely filled in by	Me	29b. Signature and title of certifier		1.1	29c. Lice	nse number		29d. Date	signed (Month	n, Day, Year)	
	->-0		Bankana	CALA	All Th	N D	383	92	8	120/	200x	
_	14		30. Name and address of person wh	no completed cause	of death (Item 23a) (T	(pe, Print)	1 - 7	, ,	1	-11		
f	2	ļ	BARBARA C	TRROLL	,M.D.,13	301 Yori	k Kd	., Cock	45 V	ille,	MD	
		ate	31. Date filed (Month, Day, Year) AUG 2 6 200		gistrar's Signature			/	1			
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8000/00/8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Anne Tahner 2008  $A^{M}$ 2:50 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Potomac Valley Wellness Center Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) February 5, 1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min 1 □ M 2 🕅 F 89 Pennsylvania 207-10-8076 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Olney Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4909 Continental Drive 20832 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 📉 No 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates Specify: White Specify: Completed by 3 X Widowed 4 □ Divorced 16a Decedent's Usual Occupation 16h, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Food Service Worker Elementary/Secondary (0-12) College (1-4or 5+) Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alex Sokalsky Anna Muzeka ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nanette F. Miller / Daughter 4909 Continental Drive, Olney, Maryland 20832 20b. Place of Disposition (Name of cemetery ciematory or other place).
Cedar Hill Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition Date August 30, 1 H Burial 2 ☐ Cremation Allentown, 3 Removal from State 2008 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 21. Signature of Fundal Service Licenses Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 M01305 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Years Dementia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami and burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p for use as 1 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 s perform 1 □ Yes 2 X No 1 ☐ Yes 2 ☐ No ors after death.

eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

31. Date filed (Month, Day, Year) State Registrar AUG 25

29b. Signature and title of certified

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.

2401 Research Blvd., #300, Rockville, Maryland 20850 Anurita Mendhiratta,

29c. License number

D38262

29d. Date signed (Month, Day, Year)

August 25, 2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) SUZANNE DESMARAIS 5:30 A.M VINYARD 25, 2008 August 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 902 Old Oak Road Stoneleigh **Baltimore** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday 1 Year Days 1 □ M 2 V F 45 218-72-0366 Jan. 14. 1963 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Maryland Baltimore Stoneleigh 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 902 01d 0ak Road 21212 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 21 No Specify. Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 3 years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth Desmarais Anne Campbell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Health tem 27

**Physician** 

/Medical

10a. State

Directo

Funeral

þ

Completed

Be

Curtis Vinyard

29b. Signature and title of certifier

1650 Orleans 31. Date filed (Month, Day, Year)

AUG 2 6 2008

Z

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State

20a. Method of Disposition

Examiner

**Funeral** 

Director

show a or 28a-f sho

ed other than "natural", or items 23a event, the Medical Examiner must b

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

attending p

Division or Vital Records, P.O. Box 68760,

	4 □ Donation 5 □ Other (Specify)		reen Mount	Crematory	8-26-08	Baltimor	e, Maryland
	21. Signature of Funeral Service License	vaire	Mitc	and Address of Facility hell-Wiede O York Road	feld Funera d Baltimor	l Home. In	C.
	23a. Part1. Enter n e dise e, or complic shock, or heart failure. List only on	eations that caused the de e cause on each line.					Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons		it cance			9 years
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.	Due to (or as a cons					
ical Exa	resulting in death) Last	Due to (or as a cons	equence of):				
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 10 9 □ Unknown	ic. If yes, outcome pf pre 1□Live birth 2□F 4□Pregnant at time o 9□Unknown	etal death 3 □Ectopic			23d. Date of de Month	l elivery Day Year
ed by Pr	Part II. Other significant conditions con	tributing to death but not r	esulting in the underlying	g cause given in Part I.		obacco use contribute i	to the cause of death? Probably 4 □Unknow
Complet					24a. Was autoj perfo 1 Yes	osy prior to ormed2 death?	autopsy findings availab completion of cause o s 2 \sum No
Be	25. Was case referred to medical examiner?				of Death (Check only of		
은	1 Yes 2€ 40	ospital: 1 ☐ Inpatient 2	☐ ER/Outpatient 3☐	DOA Other: 4 □ Nu	rsing Home 5 Resi	dence 6 □Other (Sp.	ecify)
	27. Manner of Death  atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe 1	how injury occurred	
al Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - Abbuilding, etc. (Spe	home, farm, street, fact	ory, office	28f. Location (S City or Tou	Street and Number or F wn, State)	Rural Route Number,
ia C		Ician: To the best of my l					

902 01d 0ak Road

Place of Disposition (Name of cemetery, crematory or other place)

(husband)

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore,

Maryland

20c. Location - City or Town, State

8/26/08

21231

State Registrar

within 24 hours a To the Funeral I

Room

2. Registrar's Signature

29c. License number

028239

Baltimare

Physicia	İ
/Medica	į
Examine	ĺ

To the Hospital or Attendia within 24 hours after death, To the Funeral Director: A completely filled in by the fu Medical Certificati		To the Hospital or Attending Physician: The law requires that the death certificate be executed with the Maryland to the Hospital or Attending Physician. The law requires that the death certificate be executed with the Maryland before the Maryland to the Hospital Physician and to the Funeral Director: After this certificate has been signed by the attending physician and to the Funeral director. After this certificate has been signed by the attending physician and to the funeral director. After this certificate has been signed by the attending physician and to the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director and the funeral director and the funeral director and the funeral director. After this certificate has been signed by the attending physician and the funeral director. After this certificate has been signed by the attending physician and the funeral director. After this certificate has been signed by the attending physician and the funeral director. After this certificate has been signed by the attending physician and the funeral director. After this certificate has been signed by the attending physician and the funeral director. After this certificate has been signed by the attending physician and the funeral director. After this certificate has been signed by the attending physician and the funeral director. After this certificate has been signed by the attending physician and the funeral director. After the funeral director and the funeral director and the funeral director and the funeral director and the funeral director and the funeral director and the funeral director and the funeral director and the funeral director and the funeral director and the funeral director and the funeral director and the funeral director and the funeral director and the funeral director and the funeral director and the funeral director and the fune	Medical Certification: To Be Completed by Physician/Medical Examiner	1 1 1 1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2
To the Hospita within 24 hours To the Funeral completely filled		I or Attending Physician: The law a state death of the Library Director. After this certificate has but in by the funeral director, page 2 sh	ertification: To Be Comple	2
iti	)	To the Hospital within 24 hours To the Funeral completely filled	Medical Co	34

1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year William C. Valentine 3:00 AM August 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore 2914 Onyx Road Parkville 8. Date of Birth (Month, Day, Year) 11/22/1925 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Min. Days 11XM 2□ F Months Hours 219-16-5202 82 Maryland Isual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits l0a, State 10b. County 1 □Yes 2 No MD Baltimore Parkville 10g. Citizen of What Country? 0e. Street and Number 10f. Zip Code 21234 2914 Onyx Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 1. Marital Status 1 Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 💆 No Specify: Year or Dates: WWII 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Police Officer 12 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Christopher Valentine Rosalie Spinek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William M. Valentine/ 2914 Onyx Road, Parkville, MD 21234 Son 20b. Place of Disposition (Name of cemetery crematory or other place Sac 160 Heart Of Jesus Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 08/28/08 Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) Cenetery 21. Signature of Funeral Service Licensee Evans Funeral Charlet & Cremetion Services 8800 Harford Rd. Parkville, MD 21234 Approximate Interval Between Onset and Death 23. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. ate Cause (Final diese or condition esulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE; 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 1 □ Yes 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only on Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 7. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and 0 0. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd. Parkville, MD 21234 8113 Harford anayjotis A.Baltatzi State Registrar

Baltimore, Maryland 21215-0036

Funeral

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, Stat Registra DHMH 17 Rev 1/2001 **ORIGINAL** 

	State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the S		lental Hygiene Reg. No		2712					
ian	1. Decedent's Name (First, Middle, Last)	VAGNER	2. Date of Death Month Da 08 16	Year 3	Time of Death					
lical iner	4a. Facility Name (If not institution, give street and number)  4b. City, Town	n, or Location of Death	40.	. County of Death						
i r	5. Social Security Number 215 07 7462 6. Sex 1 Months Da	ar If Under 24 Hrs.	8. Date of Birth (Month, Day, Year) 09 04 19	9. Birthplace Country) Mary						
To Be Completed by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes 2 Maries 1 Ves 2 Ves 2 Ves 2 Ves 2 Ves 2 Ves 2 Ves 2 Ves 2 Ves 2 Ves 2 Ves	21122 of Hispanic Origin? (Spe Cuban, Mexican, Puerto	ecify Yes or No-	tizen of What Country?  U • S • A •  14. Race - American Black, White, etc.	Indian,					
Be Completed b	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use rei  1 2 Homemake  17. Father's Name (First, Middle, Last)	ne during most of working tired)  2.7  18. Mother's Name	O (First, Middle, Maiden	Wn1 ind of Business/Indust						
To	John Hapij  19a. Informant's Name/Relationship (Type. Print)  George Wagner - Son  20a. Method of Disposition  1M Burial 2 □ Cremation 3 □ Removal from State  18b John Hapij  19b. Mailing Address (Str. 3014 Bayo)  20b. Place of Disposition (Name of cemetery, crematory or other)	nne Ave.	Baltimo		21214					
. Alles	4 □ Donation 5 □ Other (Specify) Holy Cross Ce  21. Signature of Funeral Service Licensee 22. Name and Ad		Gonce Fu	ltimore, neral Hon						
dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Mypertensive Atherosclerotic Cardiovascular  Due to (or es a consequence of):  Disease  35 yrs  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ★No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnant at time of death 5 □ Other (specify 9 □ Unknown			23d. Date of delivery Month Da	y Year					
þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.		use contribute to the c						
Completed			24a. Was an autopsy performed? 1 □Yes 2. ■No	death?	etion of cause					
Certification: To Be	27. Manner of Death  1	njury at Work? 1 □Yes 2 □No	me 5 Residence 28d. Describe how inju 28f. Location (Street a. City or Town, State	iry occurred nd Number or Rural Re	oute Number,					
edical Ce	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the basis of examination and/or investigation, in rand manner stated.	ie time, date and place, ny opinion, death occurr	and due to the cause(s red at the time, date an	s) and manner as state ad place, and due to the	ed. e cause(s)					
Me	m Lyulnly. DO	0021703		ate signed (Month, Day $/22/2008$	/, Year)					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Michael F. Garahy, MD 8651 Ft. Smal									

		Please	Type or Prin							_	e.	
		For State	State of Ma	arylan						000	20 07	100
		State Registrar	- 0		Cer	TITICAL	e of D	veatn	2. Date of Deat	eg. No. 2	3. Time of	436
Physicia /Medic		1. Decedent's Name (First, Middle, L.	hy		_ l	Jal	ma	4	Hugust	- 32 ž	00812:55	
Examine	er	4a. Facility Name (If not institution, gi	ve street and number)	1	nie	4b. City,	Town, or	Location of Death	ı	ANNE	Death	/
Funeral		5. Social Security Number 6.	Sex 7. Age	الازم In yrs. ie (In yrs. i	last birthday)	If Unde		If Under 24 Hrs.	8. Date of Birth	1 9	). Birthplace <i>(State</i> o	r Foreign
Director		212-20-5583 Usual Residence of Decedent	1□ M 2 <b>2</b> F	89	Yrs.	Months	Days	Hours Min.	09/26/	1918	Marylanc	1
ryland how		10a. State 10b. County		10c. City	y, Town or Loc	cation					10d. Inside Cit	
e Ma	Director		Arundel	F	asade						1 □ Yes	2 1NO
with the	Ö	10e. Street and Number				10f. Zij		0		I0g. Citizen of Wh		
eath v	Funeral	8577 Main Aver	12. Was Decedent B	Ever in U.	S. 13. V		2112 dent of His		pecify Yes or No-	U.S.A	American Indian,	
72 hours after death with the Maryland 72 hours after death with the Maryland inatural", or Items 23a or 28a-f show dical Examinar must be notified at		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ ✓ If Yes, Give			fYes, spe 1 ∐Yes		n, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		White, etc.	
ural",	d by	3  Widowed 4 □ Divorced	Year or Dates:							Specify:	White	
n 72 hours "natural";	lete	15. Decedent's E (Specify only highest g	rade completed)		16a. Deced	dent's Usu kind of wo DO NOT u	ial Occupa ork done di ise retired)	ition uring most of work	king	16b. Kind of Busin	ness/Industry	
l withii jiene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		nema				Own	Home	
other vent,	Be C	17. Father's Name (First, Middle, Las	t)					18. Mother's Nam	ne (First, Middle,	Maiden Surname)		
Ment Ment arked	2	Paul Moore						Carri	Le Wild	berger		
2 shc 2 shc is mar raum		19a. Informant's Name/Relationship								r, City or Town, St		
Health		Charlotte Verb	us/Daught						Pasader	1a, MD . 20c. Location - Ci	21122	
permit. Pages I and 2 should be filed within 72 permit. Pages I and 2 should be filed within 72 important: If item 27 is marked other than "n, any injury or other traumatic event, the Medionce.		1 Burial 2 ☐ Cremation 3			lace of Disposemetery, cren							
nit. P artme ortan Injur		4 ☐ Donation 5 ☐ Other (Spec		LOU	22	2. Name a	nd Addres	s of Facility G.	J. Gond	e Funer	ore, MD al Home,	PA
permi Depar Impo any Ir		1/1/2			1						MD 2112	
Physician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List onlinediate Cause (Final disease or condition resulting in death)	mplications that caused y one cause on each lin a.  Due to (or as	W6	TC		de of dying	1	or respiratory an	rest,	Approximate Interval Bet Onset and I	ween
Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	a consequ	uence of):		<u> </u>					
be executed sician and burial-transit	Examiner	that initiated events	c									
S cia be	alEx	resulting in death) Last	Due to (or as	a consequ	uence of):							
icate physis the			d									
The law requires that the death certificate ate has been signed by the attending physioage 2 should be detached for use as the the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 🗀 Feta	Ideath 3□	∃Ectopic ∃Other <i>(</i> s	pregnancy pecify)			23d. Date Mont		Year
that the ed by detac		Part II. Other significant conditions	contributing to death bu	ut not resi	ulting in the ur	nderlying	cause give	n in Part I.	23e. Did to	bacco use contrib	ute to the cause of o	leath?
w requires that the dispense is been signed by the should be detached	ed by								1 □ Y	es 2 □ No 3	☐ Probably 4 ☐	nknown
e law reh has bee	Completed								24a. Was a	an 24b. We	ere autopsy findings or to completion of c	available
	Com								perfor	med? de	ath? □Yes 2 🗖 №	adoc or
sician: The certificate ector, pag	Be (	25. Was case referred to medical examiner?	11				Oth		th (Check only or	ne)		
Physi this c	2	1 Yes 2 No	Hospital: 1 Inpatie		ER/Outpatier			4 LI Nursing H	T	lence 6 Other		
Attending Physician: r death. ector: After this certific by the funeral director, I	tion	1 ☐ Natural 5 ☐ Pending	(Month, Da	y, Year)	Injury	'м	28c. Injury Work 1 □ \	rai ? ∕es 2 □ No	280. Describe fi	ow injury occurred	1	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	2 Accident Investigati 3 Suicide 6 Could not determine	be 280 Blace of Inju	ury - At ho	ome, farm, stro	eet, factor			28f. Location (S City or Tow	Street and Number vn, State)	or Rural Route Num	ıber,
Hospita 24 hours Funera etely fille	Medical C		Physician: To the best aminer: On the basis o end manyer sta	f examina								;)
To the vithin To the compl	Me	29b. Signature and title of certifier		1 1		29	c. License	number		29d. Date signed	(Month, Day, Year)	
		> Ellet	N	ret			_X	12009	4	P/24	108	
N		30. Name and address of person wh	completed cause of d	eath (Hen	n 23a) (Type,	Print)	ank	Aria	e Glen	BURAID	21061	
Sta		31. Date filed (Month, Day, Year)	32 Registra	ar's Signā	iture	2000	P	1	1		1	
Registra	ar	AHG 2. 6	UUO   AM MEAR	the st	S Selection	C. P. C.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Witherspoon August Stephanie 22 2008 /Medical 4a. Facility Name (If not institution, give 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Prince Maryland Southern Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OI 29 1950 Birthplace (State or Foreign Country) Social Security Number In yrs. last birthday) **Funeral** 216.54-0692 Days 1 M 2 X F Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County works or Items 23a or 28a-f shov iminer must be notified at 1 ☐ Yes 2 No Clinton MD Prince Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 2 any Injury or other traumatic event, the Medical Examiner must hermone. 20735 5900 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government 12th grade Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Collier Nelson Anna ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Husband 5900 White Cowt

20b. Place of Disposition (Name of cemetery, crematory or other place) Clinton, MD 20735 Witherspoon 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State Crownsville 08 29 08 Crownsville, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral SVGS 8728 Liberty Road Randall stown MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myourded Interction **Physician** /Medical Due to (or as a conseque e of): Examiner DISEASE ORONARU ARTER if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctonic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Onknown After this certificate has been si funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2☑No Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1 Inpatient Medical Certification: To 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TODALE

**ORIGINAL** 

D40324

AUGUST 22,2008

MARYLAND 2073)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 13:36 PM AUG 21 ને૦૦૪ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner BALTIMORE 8. Date of Birth Month, Day, Year) AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days 1□ M 2 Director Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location "natural", or items 23a or 28a-f show dieal Examiner must be notified at 1√Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number vania Ar 1100 by Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No. Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical I Alameda College (1,4or 5+) Elementary/Secondary (0-12) Pharmac Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wallace 2 daylo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 19a. Informant's Name/Relationship (Type. Print) Baeto. 30 Irenda 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a, Method of Disposition Murial 2 ☐ Cremation 3 ☐ Removal from State □ Donation 5 □ Other (Specify) ture of Funeral Service License to.md.21229 m. wa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or itear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CORONARY ARTERY DISEASE HOURS **Physician** /Medical Due to (or as a consequence of) Examiner DISEASE PERIPHERAL ARTERY Sacularitially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed DIABETES MELLITUS ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_ Month Year Dav in the past 12 months?
1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Yes the Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide determined 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P19906 2008 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 900 BALTIMORE CATON SAINT AGNES HOSPITAL

Registrar

State

31. Date filed (Month, Day, Year)

3 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 11:30 P M 2008 August 23, Everett Daniel Wade /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore 209 Rolling Brook Way Catonsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 22, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 1 M 2 □ F 1923 Maryland Director 217-16-2980 85 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Catonsvile 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 209 Rolling Brook Way 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Ye ar or Dates: ₩WII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinant once. Black, White, etc. 1 ☐ Never Married 2 1 Married 1 ☐ Yes 2 🛛 No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Computer Program Analyst Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clinton Edward Johnson Wade Emma Ruth Heffner ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 Rolling Rook Way; Catonsville, MD 21228 Mary Lorraine\_Wade Date 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 8/25/2008 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Dig 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER **Physician** YRS disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) ☐Yes 2☐No signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2 No 1 ☐Yes 2 ☐No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident Director: 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 25, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1120 N. Rolling Road Catonsville, MD 21228 Kenneth H. Williams, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 2 6 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 4a. Facility Name (If not institution, give street and number) 2008 Ma /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Hella 7. Age (In yrs. last birthday) Itimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🗷 F 218-28-3168 Director April 26, 1931 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Exactions and the motified at Director 1 ☐ Yes 2 17 No arkville 10f. Zip Code mb altimore 10g. Citizen of What Country? 10e. Street and Number 9023 Yack 21234 Inited Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates; 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore County Pages 1 and 2 should be filed withir ment of Health and Mental Hygiene. ant: if Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 river 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic events. Margaret 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2123 4 19a. Informant's Name/Relationship (Type. Print) Spouse PERRING PARK RD PARKUILLE John Gilbert Wolferma 9023 20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Memorial

Aug 25,2008 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 Removal from State Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Addr ss of Facility
Evans Funeral (
8800 Harford 21. Signature of Funeral Service Licensee & Cremation Services mD 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MULTIPLE MYELOMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Cluses to rinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the burial-transit Due to (or as a consequence of) by Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2**X** No 1 Tyes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 1∐ Yes 2🕱 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural
2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

21215-0036

Baltimore, Maryland

Box (

Records,

of Vital

Division

State

Registrar

ERNESTINE WRIGHT 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2300 DULANEY VALLEY RD.

32 Registrar's Signature

30. Name and address of person who completed cause of death Item 23a) (Type

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

709

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 9:25 AM 08 18 2008 illiam /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** SAMARITAN HOSPITAL ALTI MORE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6. Sex 12 M 2 ☐ F Social Security Number **Funeral** Months Days Hours BALTIMORE, MI 1/20/1925 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show otified at 1 ☐ Yes 2 No BALTIMORE Un ector MID BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 USA 004 sad 08/02/08 Furiera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 IX Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. PT# 1019534997 MR# 212207729 C 11/20/1925 82 M MED C SOIN, PRIYANKA Pt Dir Ind: V TEAM U (UNITS) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Be Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) an 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 10 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BALTIMORE, Kobert 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Method of Disposition

1 △Burial 2 □ Cremation 3 ☐Removal from State DALTIMORE, 4 ☐ Donation 5 ☐ Other (Specify) CREMATION SERVICES Parkville 22. Name and Address of Facility apel + 21. Signature of Funeral Service Lisenses Dep. Imp. Kimberl 8800 HARFORD ROAD BALTIMORE, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that cause disease. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure / List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of) ARR /Medical **Examiner** FIBRILLATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner MYOCARDIA UTARCTION Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Be Completed by Physician/Medical ARTERY (ORONARY 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | → hknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CHRONIC OBSTRUCTIVE page 2 autopsy performed 1∏Yes 2 No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Aua 18, 2008 140, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 560 LOCH BLUD BALTIMORE, MD Registrar's Signature 16° 2008

DHMH 17 Rev 1/2001

Registrar

**Funeral** Director

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Division of Vital Records, P.O. Box 68760,	e Hospital or Attending Physician: The law requires that the death certificate be executed $\mathbf{x} \in \mathbb{R}^2$	1.24 hours allet ueath.  The four salet ueath.  The funder of the funeral director, page 2 should be detached for use as the burial-transit  The funder of the funeral director, page 2 should be detached for use as the burial-transit  The funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the funder of the fu	
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/Medical Examiner	4	1a. Facility Name (/	oblestone		er)			4b. City, Tow Silver					4c. County	of Death	1	_
Funeral Director		5. Social Security N 579 <b>–</b> 54–54	470 <sup>1</sup>	ex 7.	Age (In yrs.			If Under 1 Ye Months Da			8. Date of (Month Aug	Birth Day, Ye	1938	9. Birth Cou Gerr	nplace (State or Foreig intry) nany	חון
WOL IN	1	Usual Residence of 10a. State	10b. County		10c. Cit	y, Town	or Loca	tion		<u> </u>					10d. Inside City Limits	
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23a or 2 ust be n ral Dire		10e. Street and Nur 14532 Pet	oblestone				10f. Zip Code 20905		10g. Citizen of What C		Vhat Cou	untry?				
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar roust by nutfilled at once.  To Be Completed by Funeral Director	١.	11. Marital Status 1 □ Never M <i>a</i> rr 3 □ Widowed	ied 2 <b>X</b> Married 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 □ Yes  \rightarrow\tau\) No Specify:		Specific		k, White					
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Depart Import any inj once.		21. Signature of Fu	uneral Service Licer	Le Oto	∠ MO	1251	Go Be	Name and A ing Ho verly	ddress of Fa me Cr L. He	eckrot	on Ser	vice A C	e P.C Larksv	). Bo	ox 784 e, MD 21029	9_
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ORIGINAL

Regist DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 1 | 8 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 23, 2008 Year **Physician** 8:57 РМ Wilson Arlette Tetu /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Towson Blakehurst If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 10,1921 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Months Days Hours 1 □ M 2**X**□ F Rhode Island 87 Director 220-14-2375 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, I're Modical Examiner must be motified at 1 ☐Yes 2 ☐ No Director Towson Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21204 U.S.A. 1055 W. Joppa Road, #321 Funeral and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Completed by Specify. 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Classical Pianist Music 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Tiemever ၉ Arthur Α. Tetu 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Millers, Maryland 21102 Kimberly W. Hershfeld Daughter 21027 Gunpowder Road 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 8-29-2008 | Pikesville Maryland Signature of Fundral Stryice Licensee 22. Name and Address of Facility Ruck TowsonFuneral Home, Inc. Towson, Maryland 21204 1050 York Road Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CAMPLICATIONS **Physician** disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner Sequentially list conditions, from leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 DNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has bil director, page 2 sh was .... autopsy performed? Ves 2 Wo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Whursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NGUST 25 2008

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month

and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Signature

Charles ST DONSON NO

State of Maryland / Department of Health and Mental Hygiene 27444 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Dey **Physician** August 21, 2008 4:20 pm Helen Anna Rose Walinchus /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Towson Under 24 Hrs. Manor Care Ruxton Baltimore 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** Min. Days Hours 1□M 2√2 F Yrs. 215-10-2869 90 10, Marvland Director Usuel Residence of Decedent filed within 72 hours aftar death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or tems 23s or 28s-f show other traumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Towson 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 7001 N. Charles Street 21204 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 🎾 No ģ Specify: ¾☐ Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pagas 1 and 2 should be Department of Haaith and Mantal Important: If Item 27 is marked or G. Mitch, Sr. Joseph Elizabeth Pechulis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Robert J. Walinchus / Son 10953 Rocky Mount Way Wheaton, Md. 20902-3687 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Cem. 8/26/08 Baltimore, Maryland 21. Signature of Funeral Service Licensee, 22 Name and Address of Fecility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 a 23a. Part1. Enter the disease, or co-pit wons that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) INANITION Examiner Due to (or as e consequence of): Examiner ALZHEIMERS EMENTIA Attending Physician: The law requires that the death cartificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequence ot): Box 68760. Physician/Medical Due to (or as e consequence of): Part It. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 □ Probably 4 ☑ Unknown ģ 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? 2 SNO 1 ☐ Yes 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: ဥ 2000 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Maturat 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Yeer) 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) N. Charles H., 209, Bolto, MD 21204 GAN-CARDEN 6565

**DHMH 16 Rev 6/95** 

State Registrar

31. Date filed (Month, Day, Year)

32. Registrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** AUGUST 2008 MARGARET WALLENHORST 7:35 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD FOREST HILL HEALTH AND REHABILITATION FOREST HILL 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 X F SEPT 23 1912 09 6078 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State r 28a-f show notified at 1 Yes 2 No HARFORN mo FOREST Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Items 23a or 2 Iner must be n Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 21050 USA VALLEY DRIVE Completed by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or Item edical Examiner r Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 WHITE 3XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 27 Is marked other than "nature traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) W. J. DICKEY Elementary/Secondary (0-12) College (1-4or 5+) PATIERN MACHINE OPERATOR 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) CANAPP ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AIR, MO item 27 I 21015 621 WEATHERBY CHARES WALLENHORST, SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 22. Name and Address of Facility / ZUMBRUN FH & MON CO. South CARROIL Greme 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Party Extent the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ELDAUBURG MO 21784 Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequent of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Useaase or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director; After this certificate has been signed by the attending physician and attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal dea 4☐Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months?
1 Yes 2 No 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 \(\frac{1}{2}\)\(\frac{1}{2}\) 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 □ Yes 2 □ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide 24 hours a 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

within 24

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Bown 50

AUG 2 5 2008

MACPHAIL ROAD - BEL AIR, MD 21014

29c. License number

032299

29d. Date signed (Month, Day, Year)

august 25, 200

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID DUNN - 615 W. MACPHAIL It te filed (Month, Day, Year) 22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 21 Zas Benjamin Ziegel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner n/a MORE カノノイノ 1000 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 💢 M 2 🗆 F Director 216-12-9363 March 20. Maryland Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location i-f show 10a State 1 ☐ Yes 2 ☑ No Director Timonium Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21093 2525 Pot Spring Road Unit 609 Funeral 03/11/08 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No \$ Specify. White 3 XWidowed 4 ☐ Divorced WW II ZIEGEL , ADAM PT# 1019569829 MR# 901001204 \03|20|1924 84 M IMC Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pt Dir Elementary/Secondary (0-12) College (1-4or 5+) Tavern Owner Hospitality 12 n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HERBERT Julia Wisnewski Adam B. Ziegel ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10705 Pot Spring Road Cockeysville, Maryland 21030 Mrs. Sharon Mech (Daughter) permit FRIEDMAN, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Other (Specify) Entonbrent 8/25/2008 4 ☐ Donation Dulanev Vallev Mem. Maus. Timonium Maryland Import any inj once. 21204 21. Signature of Foneral Sen 22. Name and Address of Facility Bal Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEHMONIA **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner DECONDITIONIN Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of as the burial-tran Due to (or as a consequence of) Divísion of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) I □Yes 2 □ No detached i 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No DEMENT 24a. Was an has autopsy certificate 1 Tyes Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21 0 BLUD BALTIMORE AVEN 3 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Alvin Brown 2008 omas /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner 6 Maralana iona 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) cial Security Number Age (In yrs. last birthday) **Funeral** Days Hours 1XM 2□F APR. 20, 1948 MARYLAND Director 214-48-5842 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 28a-f show 1 XYes 2 ☐ No f Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f sh other traumatic event, the Medical Examiner must be notified. Director PRINCE GEORGES LAUREL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filled within 72 hours after death with nent of Health and Mental Hygiene. U.S.A. 13903 BRIARWOOD DR. #813 20708 Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☑ Divorced BLACK Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LAW ENFORCEMENT SPECIAL POLICE 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WOODLAND **JAMES** FRANKLIN EVANGELINE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ε. 13903 BRIARWOOD DR.#813, LAUREL, MD. 20708 SHARON FLETCHER/FIANCE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 8-15-2008 RIVERDALE, MD. 21. Signature of Funeral Service Licenses FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardiac **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner umon ares Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury to (or as a consequence of Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed that initiated events resulting in death) Last bunal-tran Division or Vital Records, P.O. Box 68760, Uncontrolled Physician/Medical the as attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Year Month in the past 12 months? Day 5 ☐ Other (specify) ☐Yes 2☐No ed by the detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1 🗆 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 2**X**No 1 Inpatient 1 ☐ Yes Medical Certification: To this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After 1 Natural 2 ☐ Accident (Month, Day Year) 5 ☐ Pending investigation 1 □ Yes 2 □ No Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office 4 Homicio 29a. Certifier

24 hours aft e Funeral Di letely filled in To the

Homicide	aeteminea	building, etc. (Specify)		City or To	wn, State)
Certifier (Check only one)	Certifying Physic 2 Medical Examine	ian: To the best of my knowledge, death on the basis of examination and/or investand manner stated.	occurred at the time, date and place estigation, in my opinion, death occu	e, and due to the urred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
Signature and	da IMCA	zec, Mo	29c. License number D053840		29d. Date signed (Month, Day, Year)  08/08/2008

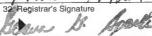
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAUREL PARK CTR. DR. #102, LAUREL, MD 2070 MCGEE, MO

31. Date filed (Month, Day, Year)

29b. Signature

AUG 11 2008



State

Registrar

		State of Maryland / Dep	artment of Health and artificate of Death	Mental Hygier	71118 / / 1440
_		Registrar  1. Decedent's Name (First, Middle, Last)	Timodio oi Bodii.	2. Date of Death	3. Time of Death
Physicia /Medica		Charles Marlin Bowers, Sr.			Дау 2008 3:50 A м
Examine		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dear		4c. County of Death
·		9823 Old National Pike  5. Social Security Number 6. Sex, 7. Age (In yrs. last birthday,	Hagerstown  If Under 1 Year   If Under 24 Hrs		Washington County  9. Birthplace (State or Foreign
Funeral Director		5. Social Security Number 1. Age (if yis, last birthday, 217—24—6553 1. Age (if yis, last birthday, 77 Yrs.	Months Days Hours Min		930 Maryland
pu »		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L.	conting		10d. Inside City Limits
farylan s show	ō	Maryland Washington County Hagerstow			1 □Yes 2 No
the N	rect	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
h with	al Di	9823 Old National Pike	21740	U	.S.A.
	by Funeral Director	11. Marital Status  1  Never Married 2  Married  3  Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2  No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puel 1 □Yes 2 → No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
2 hou	sted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation	nrking 16b	Kind of Business/Industry
/ithin 7	Completed	Elementary/Secondary (0-12)   College (1-40r 5+)	e kind of work done during most of wo DO NOT use retired)		uilding Contractor
Hygie v		12 Owner  17. Father's Name (First, Middle, Last)		me (First, Middle, Maid	
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and 2 ealth m 27 her tra			3 Old National Pil		
permit. Pages 1 and 2 Department of Health Important: If Item 27 any Injury or other fr			osition (Name of ematory or other place)		Location - City or Town, State
nit. Pa artmer artmant ortant injury			wn Mem. Park 8-16		gerstown, Maryland iery Funeral Home
permit. Departr Imports any Inji		1 June 100 - N. Fine 1	331 Eastern Blvd.	North Hag	erstown, MD 21742
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or hear/failure. List only one cause on such line.	nter the mode of dying, such as cardia	ac or respiratory arrest,	litter var between
Physician	8 1	Immediate Cause (Final disease or condition	Failur		Onset and Death
/Medical Examiner		resulting in death)  Due to (or as a consequence of):	- Ax 1- Du	conso	Yours
	ie	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of the conditions)	1	(1)	16000
cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	OPET LU	UT XI	Blase Icars
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physicate I	dical	d. To allow the			Lycolo
n certif	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
ires that the death certification is greed by the attending of the detached for use as	Physician/Me	in the past 12 months?  1   Yes 2   No   1   Live of the 2   Petal death 3   4   Pregnant at time of death 5   9   Linknown	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
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w requir	lete	1/		24a. Was an	24b. Were autopsy findings available
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stan:	Be C	25. Was case referred to medical examiner?		eath (Check only one)	
ding Physician: The Ind. After this certificate he funeral director, page		1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient		Home 5 Residence	e 6 Other (Specify)
ding I	tion	1 Pending (Month, Day, Year) Injury		250. Describe now	injury occurred
Atten r deat ector: by the	ifica	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Rural Route Number,
tal or rs after all Dir	Certification: To	4 Homicide building, etc. (Specify)		City of Town, c	nate)
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  If the Honeral Director: After this certificate has been signed by the attending Completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certified (Check lonly one)   Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and pla investigation, in my opinion, death oc	ce, and due to the cause curred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
To the within Somple	Mec	29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Month, Day, Year)
25		I Au au mo	2004503	31. a	ug 14 2008
10		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) Ha Dra	stown	an 21200
Sta	te	31. Date filed (Month, Day, Year)  32. Figure 32. Signayare	1 kg	0.0.0.	000172
Registra		AUG 1 5 2908	Level O		

			For amend #23a	Per PHY G	ryland	12978	rtment of H tificate of I	lealth and Death	i Mental Hy	giene	2000	07110
		-	Registrar  1. Decedent's Name (First, Middle, La	et)		Cei	illicate of i	Jean	2. Date of De	Reg. No.	2000	3. Time of Death
	Physici			,					Month AUGUST	Day	Year	1:40A M
	/Medic		Willard Edwin  4a. Facility Name (If not institution, give	Broadwat	er		4b. City, Town, or	Location of De			County of Death	
	LAGIIII		MEMORIAL HOSPIT	ΔΤ.			CUMBERI	AND		ALI	LEGANY	
30 E	Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. las	st birthday)	If Under 1 Year Months Days			rth av. Year)	9. Birth	place (State or Foreign intry)
2	Director		220-34-1544	1 <b>⊠</b> M 2□F	71	Yrs.	WOTHIS Days	TIOUIS III	01/18/			yland
	w		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation		-			10d. Inside City Limits
	Maryli f sho ied at	ō	MD Garret	<b>+</b>	Stat	anton						1 □Yes 2 No
	the 28a-	Director	10e. Street and Number	L	- OW	ancon	10f. Zip Code			10g. Citize	en of What Cou	intry?
	h with		1322 Broadwater	Drive			21561				USA	
	deat	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. \	Vas Decedent of H f Yes, specify Cuba	ispanic Origin?	(Specify Yes or No	o- 1	4. Race - Amer Black, White	
9	or ite	y Fu	1 ☐ Never Married 2 ☒ Married	1 ☐ Yes 2 ☑ N If Yes, Give	0		I∐Yes 21⊠No	Specify:	,		Specify:	, 0.0.
8	hours ural"	d by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E	Year or Dates:		160 Doors	lent's Usual Occup	otion			d of Business/li	nite
<del>ر</del> ې	n 72 "nat	lete	(Specify only highest gra	ade completed)		(Give	kind of work done o OO NOT use retired	durina most of v	vorking	TOD. KIN	d of business/ii	lidustry
712	with jiene. r thar the N	Completed	Elementary/Secondary (0-12) 10th	College (1-4or 5-	+)	Far	mer/ Car	penter		Fari	ming/ C	onstruction
פ	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last	)					lame (First, Middle			
<u> a</u>	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	To E	Everett Br	coadwater				Lucre	tia	]	Broadwa	ter
Maryland 21215-0036	and and sum	ľ	19a. Informant's Name/Relationship	7,			g Address (Street					ip Code)
	is 1 and 2 of Health item 27   other tra		Hazel E. Broadwat	er/ Wife	20h Pla		Broadwa	ter Dr.	, Swantor		21561 ation - City or 1	Four State
ğ	/h O		1⊠Burial 2 ☐ Cremation 3 ☐		cen	netery, crer	natory or other plac	´ į			,	
altimore,	it. Partmer	10	4 ☐ Donation 5 ☐ Other (Special Service Lice		Mead	low Mt	n.Church Name and Addres	Cem. 8	/16/08	Bit	tinger,	Maryland
Ba	permit. Page Department of Important: If any injury or once.	e je	Vant Di	Mint	10		.O. Box					
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	pplications that caused	the death.							Approximate Interval Between
	Physician	7 16	Immediate Cause (Final disease or condition	Multip		1000	aa Multi	ple My	o 1 oma			Onset and Death 2/2005
6	/Medical		resulting in death)	Due to (or as a			·	pic iij	Стоща			2/2003
	Examiner		Sequentially list conditions.	b								
	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	conseque	nce of):						
EC.	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a	conseque	nce of):					-	
8760	ate be executed hysician and the burial-transit	dical E		►d.								
9		ledi							*1.14)	1		
Box	leath certific attending p I for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p			Ectopic pregnancy	,		2:	3d. Date of deli	,
О. Е	he lav requires that the death certific e has Leen signed by the attending p ige 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at			Other (specify)				Month	Day Year
Δ.	that the de led by the detached	Phy	9 ☐ Unknown  Part II. Other significant conditions	contributing to death but	t not resulti	ing in the u	nderlying cause give	en in Part I	23e Did	tohacco us	se contribute to	the cause of death?
Vital Records,	signe signe	l by	Tak II. Other signmount conditions	sommoung to death bu	t not result	ing in the di	idenying dadae giv	on are are a.				bably 4 X Unknown
ö	v require	Completed	-								24h Mara au	tonov findings available
æ	he lav e has ge 2 :	шb							– auto		prior to c death?	topsy findings available ompletion of cause of
ta	m 0		25. Was case referred to medical					26 Place of I	1  Yes Death (Check only		1 LJYes	2 □ No
	ysicia is cer direct	To Be	examiner? 1 ☐ Yes 2 🎇 No	Hospital: 1 XInpatier	nt 2 EF	R/Outpatien	t 3 DOA Oth	or.	g Home 5 ☐ Res		☐Other (Spec	eifv)
Division or	ding Phys h. After this funeral dii		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 2 Year) 2	28b. Time of Injury	28c. Injur Wor		28d. Describe			·
<u>S</u>	ttendii leath. tor: A the fu	atic	2 ☐ Accident investigatio				M 1 🗆	Yes 2 □ No				
5	r At er d irect	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ry - At hom . <i>(Specify)</i>	ie, farm, str	eet, factory, office		28f. Location ( City or To	(Street and wn, State)	l Number or Ru	ral Route Number,
_	0 # 5 5				f mv knowl	edge, deat	occurred at the tir	me, date and ni	ace, and due to the	cause(s)	and manner as	stated
	spital or ours afte leral Dii filled in		29a Certifier 1 X Certifying Pl	vsician: To the best of								
	e Hospital o 124 hours aft e Funeral Di letely filled ir			nysician: To the best o miner: On the basis of and manner sta			rootigation, at my c	pinion, dodin o			p	to the cause(s)
۵	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical Ce	(Check only 2 Medical Exa	miner: On the basis of			29c. Licens				e signed (Month	
	To the Hospital o within 24 hours aft To the Funeral Di completely filled in	edical	(Check only 2 Medical Exa	miner: On the basis of			29c. Licens			29d. Date		
	To the Hospital o within 24 hours aft To the Funeral D completely filled in	edical	29b. Signature and title of certifier  30. Name and a divise of person who	miner: On the basis of and manner star	path (Item 2	23a) (Type,	29c. Licens	e number	71	29d. Date	signed (Month	n, Day, Year)
		(C) Medical	29b. Signature and title of certifier  30. Name and a divise of person who Dr. Qamar Zaman	completed cause of de	eath (Item 2	23a) (Type,	29c. Licenson	e number	71	29d. Date	signed (Month	
	To the Hospital of within 24 hours aff within 24 hours aff of the Funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the funeral Discompletely filled in the	e Medical	29b. Signature and title of certifier  30. Name and a divise of person who	completed cause of de	eath (Item 2	23a) (Type,	29c. Licens	e number	71	29d. Date	signed (Month	n, Day, Year)

		•	1 - For Amend Item 28b, e, f, per me, go	82.08/26/08dhb rtificate of Death	Reg. I	1e2008	2/450
	Physicia	n	1. Decedent's Name (First, Middle, Last)  Larry Ronald Ball		2. Date of Death August	7° 20° <del>0°</del> 8	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	9:20 A <sup>M</sup>
		·.	Prince George's Hospital	Cheverly		Prince G	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) $215-52-7530$ 1 M $_2\square$ F 60 Yrs.	Months Days Hours Min.	B. Date of Birth (Month, Day, Yea July 28	9. Birthp Coun	lace (State or Foreign ltry) lifornia
			Usual Residence of Decedent		July 20		
	show	or	10a. State     10b. County     10c. City, Town or Low       MD     Charles     Waldon			1	0d. Inside City Limits 1 ☐ Yes ※XNo
	the M	Director	MD Charles Waldor  10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coun	try?
	h with	al Di	1409 Harwich Circle	20601		U.S.A.	
	tems tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Americ Black, White, e	
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Modical Examiner must be modified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 □Yes 2x No <i>Specify:</i>		Specify: Wh	ite
Maryland 21215-0036	72 hou natura	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	16b.	Kind of Business/Ind	lustry
121	be filed within 72 ho ital Hygiene. d other than "natui event, it e it silosi	Jdmo	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working DO NOT use retired) Ctrician		BEW Loca	1 26
<u>0</u>	e filed val Hygid other vent, II	Be Co	17. Father's Name (First, Middle, Last)	18, Mother's Name (			<u> </u>
/lan		To B	Harold James Ball	Elsie	May Jac	kson	
/ar	2 sho n and l			ng Address (Street and Number or Rural			Code)
	s 1 and 2 should I Health and Mer tem 27 is marke other traumatic		20a, Method of Disposition 20b. Place of Disposition	Harwich Cr. Wa estion (Name of matory or other place)		Location - City or To	wn, State
E E	e = 'e			matory or other place)  e Mem.Cem. 12,20	08 W	aldorf,	MD
Baltimore,	permit. Pag Department Important: any injury once.			2. Name and Address of Facility Ray 5635 Washington		nl Servi	ce,P.A.
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			114547	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	ewenhal	opatto	/	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as consequence of):	1 0 1000	1		
		e	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):	tery arre	-37		
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	- chest t	vayin	ia _	
50,	tificate be executed g physician and as the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):	Jordon Kis	net		
68760	tificate ng physi as the t	edical	d	Do Africa,			
Box	eath certi attending for use a	JW/W	IF FEMALE: 23b. If yes, outcome of pregnancy in the past 12 months?  1 ☐ Live birth 2 ☐ Fetal death 3 [	☐ Ectopic pregnancy		23d. Date of delive	
0.8	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	Physician/M		Other (specify)		Month	Day Year
σ.	s that the de ned by the a detached t	by Ph	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the	ne cause of death?
Records,	law requires t nas been signe s 2 should be o	ed b			1 🗆 Yes	2 No 3 Prot	pably 4 thknown
ဒ္ဓင္	law re has be	Completed			24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
_	sician: The law certificate has b irector, page 2 s				performed	? death? No 1 □ Yes	2 □No
Vital	ysicia s certi directo	To Be	25. Was case referred to medical examiner?  1 XYes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death		e 6 ☐ Other (Specia	
Division of	ding Physician: h. After this certific funeral director,	T:uc	27. Manner of Death  1 Natural  5 Pending  (Month, Day, Year)  28b. Time of (Month, Day, Year)	f 28c. Injury at 28 Work? 28	Bd. Describe how in		00-
<u>S</u>	ttendi death. tor: A	icati	2 D'Accident investigation 7 2 0 8 10:13		Pf Lagation (Street	16 Card	a & V
<u>&gt;</u>	al or At after d Direct d in by	Certification:	determined  4 ☐ Homicide  determined  determined  determined  determined  determined  chairing dc. (Specify)  Church	13	City or Town, Si 3804 Cent	ral Ave.,	ical Church Bowie,MD
	e Hospital or Attending Physician: 24 hours atter death 24 Funeral Director: After this certifics letely filled in by the funeral director;	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.				
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
			> matillier	023442	- 8	18/04	
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) DRIVE, GR	ZEEN B	ELT	MT
į	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 6 2008 32. Registrar's Sonature	e e			
	negiali	•					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8, 3:40 P.M 2008 August Betty Ann Clark /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Shady Grove Adventist Hospital Rockville 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🗵 F Days Washington, DC Dec. 15. **Director** 218-24-1199 78 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 X No Director Montgomery Village Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20886 United States 9601 Horizon Run Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐Yes 2X No 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No If Yes, Give Year or Dates: Specify: Specify. 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: if item 27 is marked other tha any injury or other traumatic event, Ital once. Homemaker 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Goodwin Annie ပ္ John Sinclair Alexander 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9601 Horizon Run Road, Montgomery Village, MD.20886 Sandra Day/Daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 8/9/2008 |Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) ure of Funeral Service Licens 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** an /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the conditions of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed l Part II. Other significant conditions contributing to death but not resulting in the underlying suse given in Part I. Division of Vital Records, ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 □ Yes 2 2 No certificate 1 ☐ Yes 2 🗷 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medica examiner? 26. Place of Death (Check onl one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D0062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Printy Malchlar B. Rockville, MD 20850 10110 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 1 1 AUG Registrar

			1 - State of Maryland / Dep Registrar  State of Maryland / Dep	artment of Health and Nortificate of Death	Mental Hygien Reg. N	2000 21434
	Physici		1. Decedent's Name (First, Middle, Last)  Oscar Elwood Cecil		2. Date of Death Month Hugust	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Washington County Hospital	4b. City, Town, or Location of Death Hagerstown		c. County of Death Washington
I	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 ■ 1 ■ 1 ■ 1 ■ 1 ■ 1 ■ 1 ■ 1 ■ 1 ■ 1	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Year July 21,1	
П	iryland show	_	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	th the Ma or 28a-f	Director	Maryland Washington Hagerston 10e. Street and Number	10f. Zip Code	10g, C	1 ☐ Yes 2 Mo
	ns 23a o	Funeral D	13914	21740 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	US,	A 14. Race - American Indian,
38	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Exarcinet be notified at	by Fur	Armed Forces?  1 Never Married 2 Married 1 Tyles 2 No 1943— If Yes, Give 7946  Year or Dates:	If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ■ No Specify:	Rican, etc.)	Black, White, etc.  Specify: White
21215-0036	2 should be filed within 72 hours after death with the Marylar and Memlarl Hygiene. and Memlarl Hygiene is marked other than "natural", or Items 23a or 28a-f show aumatic event, it is findical Examine must be notified a	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)		Kind of Business/Industry
	filed with Hygiene ther the		12 4 Teach 17. Father's Name (First, Middle, Last)		E (First, Middle, Maide	ducation en Surname)
Maryland	ould be d Mental narked o	To Be	Oscar Henry Cecil	Ada	Hodge	
, Mar	ges 1 and 2 should it of Health and Mer If item 27 is marke or other traumatic			ing Address (Street and Number or Run Greencastle Pike		
Baltimore,	Pages 1 ent of Hi nt: If iter ry or oth			osition (Name of matory or other place)  rg Crematory 8-14	111	Location - City or Town, State  thebura. Maruland
Baltii	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau		21. Signature of Funeral Service Lipensee		me P.A. 42	5 S. Conococheague
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	Iter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	cate be executed by sician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence 1):  C. Due to (or as a consequence of):	arey aise	AL	11 MBV 1013
O. Box 68	Ine law requires that the death certificate has been signed by the attending phage 2 should be detached for use as the	Physician/Medi		□ Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P.	w requires that s been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I.		o use confibute to the cause of death? 2  10
al Records,	certificate has bee ector, page 2 sho	Completed			24a. Was an autopsy performed?	
ion of Vital	rhis ral dir	ation: To Be	25. Was case referred 1 medical examiner?  1   Yes   2   No	ent 3 DOA Other: 4 Nursing Ho	th (Check only one) ome 5 The Residence 28d. Describe how inj	
Division	the nospital of Attending hin 24 hours after death.  the Funeral Director: After hindle hind hind hind hind hind hind hind hind	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
	within 24 hours after d	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or is and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	, and due to the cause rred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	within 2 vithin 2 comple	Me	29b. Signature and title of certifier	29c. License number	3 And	Date signed (Month, Day, Year)
0	*		30. Name and address of person who completed cause of death (Item 23a) (Type	DOSZ65Z Medica/CAMP	- I Post	HAGEILITUEL
	Sta Registra	16	31. Date filed (Month, Day, Year)  AUG 1 5 2008  32. Regionar's Signature	Souls	1 Toul	110 21742

Amend 28a-b, perME, g883 9/16/08 TT

For Amend Items 28a-f per me, g883, 08/28/08db

1- Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 15 Amend Items 28a-f per me, g88a, 08/28/08dbb

Corrificate of David 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 2008 August 5:10 p George Thomas Case, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11 Low Road Earleville Cecil If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F 220-86-5231 43 DE November 29, 1964 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or Items 23a or 28a-f show idical Examiner must be notified at 1 □Yes 2 No Director MD Cecil Earleville 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 11 Low Road 21919 **USA** Completed by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married ☐ Yes 2 Yes, Give 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: 12 should be filed within 72 now...
th and Mental Hygiene.
17 is marked other than "natural" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Thomas Case, Sr. Elizabeth Batten 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once. George Thomas Case, Sr./Father 980 Telegraph Rd., Rising Sun, MD 21911 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Rosebank Cemetery August 14, 2008 Rising Sun, MD 21. Signature of Fil Hee 22. Name and Address of Facility Service Licensee Andrew G. Gee Funeral Home, 259 E. Main St., Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due tu (or all a co/s quence of): SUBBER Physician disease or condition resulting in death) /Medical Examiner Due to (or as a prequence) of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed CERTIFICATION APPROVED BY MEDI physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ۾ 2 No 3 Probably 4 Unknown cate has been sig page 2 should b 1X Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has 1□ Yes 2X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Na Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 27. Manner of Death 28b. Time of 5: 10 28c. Injury at Work? Describe how injury occurred 5 Pending investigation Subject hanged self. 1 Natural thin 24 hours after use of the Funeral Director: Aft 08/<del>10</del>/2008 <del>11:30</del> p м 1 ☐ Yes 2 🛣 No 2 Accident 6 Could not be determined 3 Suicide 4 ☐ Homicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town State) | | Low Road Earleville, MD or after Home Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AUGUST 2008 11 Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 Bowstree enflocio . Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 3 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Items 23 a First 25 per me, g882, 08/29/08dhb Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Marcellus 08 RAYMOND COLEMAN 08 10104c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death WMHS BRADDOCK CAMPUS CUMBERLAND nder 1 Year | If Under 24 Hrs. ALLEGANY 8. Date of Birth (Month, Day, Year) April 30 1931 West Virginia 7. Age (In yrs. last birthday)
77 Yrs. Months Days Hours 234-40-3569 1 XM 2□ F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County WV. Mineral Piedmont 1XIYes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 77 East Hampshire St. 26750 United States 12, Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: Korean 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Black 1 ☐ Yes 2 🛛 No Specify Specify: 3 ₩idowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Paper Manufacturer Elementary/Secondary (0-12) College (1-4or 5+) Lab Technician 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Paul Marquerite Howard Α. Coleman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marc Coleman/ son 813 Shawnee Ave, Cumberland, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other pl Sunset Mem. Park 20c. Location - City or Town, State Date 20a. Method of Disposition 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State /15/ Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Seprice Licenses 111 Church St, Westernport, Maryland 21562 30 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ladycarda Ver 1/406 disease or condition resulting in death) Due to (or as a consequence of): Hypertensive Atherosclerotic . Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ENTEROTION APPROVED BY MEDICAL EVANINE 1000 Due (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnance in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

physician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending p signed by the a Atter this certificate has been s funeral director, page 2 should it at er dea h. I Director Aff d in by the fur

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Exandrer aust be notified at

"natural"

th and Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical

Department of Health a Important: If item 27 Is any Injury or other traconce.

Physician

/Medical Examiner Director

Funeral

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Completed

Be

2

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Physician/Medical Examine δ Completed Be Certification: To 27. Manner of Death 6 ☐ Could not be 3 🗌 Suicide 4 - Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signat	ure and title of certifier		
	Travara	pan	

29c. License number

29d. Date signed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

PAZIR 901 32. Registrar's Signature umberland, MD Ameh LANANA 31. Date filed (Month, Day, Year)

State Registrar

within 24 hours at To the Funeral Di completely filled in

Medical

29a Certifier

(Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) **Physician**  $A^\mathsf{M}$ 2008 8:58 Callis 14 August Winifred Juanita /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Garrett Garrett County Memorial Hospital Oakland Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 X F 22, 1929 220-74-7094 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 TyYes 2 □ No Director 0akland MD Garrett 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number United States 706 E. Alder Street 21550 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian "natural", or Items : . Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) other than Elementary/Secondary (0-12) Disabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental F Be Nellie Swick Callis Delphus ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a 60 A. Chester Street, Front Royal, VA 22630 Brian Callis, Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cumberland Crematory 8/16/08 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 21550 V weether 23a. Part1. Enter the disease, or complications that cause i the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final noc Physician 0106 disease or condition resulting in death) /Medical Due to (or as a con: Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) ed by the a detached f 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Onknown 1 ☐ Yes page 2 should Completed 24a. Was an 24b. Were autopsy findings available has director. Be Certification: To

Division or Vital Records, P.O. Box 68760, After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu

							autopsy performed? 1 Yes 2	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No		
	Was case referre	d to medical				26. Place of Dea	ath (Check only one)			
	examiner?	6	Hospital: Inpatient 2 □	ER/Outpatient	3□ DOA	Home 5 ☐ Residence 6 ☐ Other (Specify)				
27.	Manner of Death Natural 2 Accident	5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c	. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury o	ccurred		
	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined		ome, farm, street,	factory, o	office	28f. Location (Street and N City or Town, State)	lumber or Rural Route Number,		

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) 29c. License number D23979 4-08

Robert A. Goralski, MD

311 N. Fourth Street, Oakland, MD 21550

State Registrar

Medical

29a, Certifier

29b. Signature and the

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 2.306. M 2008 Remedios Dela Rosa Dulay 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Rockville Hebrew Home of Greater Washington 8. Date of Birth (Month, Day, Y 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Hours Days Min. 1923 Philippines 1 □ M 2 🖾 F 84 356-72-4030 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 □Yes 2 No Gaithersburg Maryland Montgomery 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20879 7300 Brenish Drive 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Asian 1 ☐ Yes 2 🔀 No Specify Specify 3X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Justina Guinanao Zacarias De La Rosa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7300 Brenish Drive, Gaithersburg, MD 20879 Florita D. Nicolas (Daughter) August 7, 20c. Location - City or Town, State 20b Place of Disposition (Name of 20a. Method of Disposition Gate of Heaven 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD 2008 4 Donation 5 Other (Specify) Cemetery 22. Name and Address of Facility DeVol Funeral Home, 21. Signature of Funeral Service I 23a. Fart1. Enjet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, by free failure. List only one cause on each line. Conditional or condition resulting in death) 1.0 E. Deer Park Drive, Gaith Conditional Do not enter the mode of dying, such as cardiac or respiratory arrest, and conditional conditional death. 10 E. Deer Park Drive, Gaithersburg, MD 20877 Sequentially list conditions, Due to Kr as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23d. Date of delivery . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐Unknown 2 No 24b Were autopsy findings available prior to completion of cause of 24a. Was an

Physician /Medical Examiner The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

Completed by Funeral Director

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 21s marked other than "natural", or items 23a or 28a-f show any hijury or other traumatic event, the Medical Examiner must be notified one.

Baltimore, Maryland 21215-0036

After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transi

filled in by the funeral director, within 24 hours after death To the Funeral Director:

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

Julay Remedios

Physician/Medical Medical Certification:

Completed by To Be

Examiner

State Registrar

autopsy performed? Yes 2 146 2 ☐ No 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 | Yes 2 | No 1 Inpatient 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Injury 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certifier

0055362

29d. Date signed (Month, Day, Year)

of death (Irem 23a) (Type\_Print) 30. Name and address of person who completed cause 0 emaneute

31. Date filed (Month, Day, Year) AUG 11 2008 32. pgistrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 9:49 р м Mary Claire August 9, Doyle 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Baltimore Towson Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea, Aug. 9, 2 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days Hours 1 □ M 2 🗓 F Months 2008 Maryland None Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No York York 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1380 Bee Jay Drive 17404 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Noné None N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Shelia Conley James Robert Doyle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James R. Doyle/Father 1380 Bee Jay Drive, York, PA 17404 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/13/2008 Wicomico Memorial Park Salisbury, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility eller Funeral Home, 1212 Old Ocean City 21. Signature of Funeral Service L P. Q. Road, Box 3171 Salisbury, REMULL, MD 21802 Part 1. Enter the disease, or com<del>plications</del> that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Hinknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an eutopsy 1 ☐ Yes 2 Mo 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Director PA

Funeral

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Completed

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner in the notified at one.

Dovie, mary Cla

Baltimore, Maryland 21215-0036

sician and burial-tran attending physician for use as the buria been signed by the should be detached

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s

Division of Vital Records, P.O. Box 68760,

State Registrar

DHMH 17 Rev 1/2001

the

Examine Physician/Medical ۾ Completed Be Certification: To

5 Pending investigation

6 ☐ Could not be

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

Norma V. Gungon, M.D., 6701 North Charles Street, Towson, MD 21204

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

32. Registrar's Signature 2008

and manner stated

28a. Date of Injury (Month, Day, Year)

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 Dorothy Marie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore Upiv. of Maryland Shock Trauma Ctr. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day Year) | 1916 | April 26, 1916 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Michigan **Funeral** 1 □ M 2**K** F 374-09-2465 92 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 ☐ Yes 2 ☑ No Maryland Montgomery Silver Spring Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20910 USA 304 Wayne Place Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give Year or Dates: 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: White Ď 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude M. Schlussler Henry W. Tank ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 304 Wayne Place, Silver Spring, MD 20910 Kenneth A. DeHart/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Aug. 11 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, Maryland Parklawn Memorial Park 4 □ Donation 5 □ Other (Specify) 2008 22. Name and Address of Facility 21. Signature of Funeral Service Acenses Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death THE STRONG IN PROPERTY IN THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE P Immediate Cause (Final Intracravial Hemorrhage Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): 3 days Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): Qivision or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month in the past 12 months?
1 Yes 2 No 9 □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cerebro vascular accident and 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 22 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 XYes 2 No Medical Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 ☐ Natural Fall from standing 9:00 AM 1 ☐ Yes 2 ☑ No 08/05/08 24 hours after death. 2 X Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 301 Wayne Home Silver Spri 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Hosp within 24 hou To the Fune completely fi (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

Sublem

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Schabelman

77 2

3 Registrar's Signature

breeze

AU4176435 17523

St. Baltimore, MD 21/01

7/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 3:22 AM AUGUST 11 PAUL THOMAS FLETCHER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 1) | Min. | JUNE 30, Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 XM 2 □ F Yrs 1940 VIRGINIA 220-36-7890 68 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a State 28a-f show permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, "m. Medical Exparding must be notified at 1 ☐ Yes 2 X No Director QUEEN ANNE'S STEVENSVILLE MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number UNITED STATES 726 DIXON DRIVE 21666 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 **X**Yes 2 □ No If Yes, Give Year or Dates: **1963–1965** 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE ⋧ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER TRANSPORTATION q 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARGARET TATE PAUL W. FLETCHER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) GERALDINE FLETCHER/WIFE 726 DIXON DRIVE, STEVENSVILLE, MARYLAND 21666 20b. Place of Disposition (Name of cemetery, crematory or other place CROWNSVILLE VETERANS CEMETERY 20c. Location - City or Town, State 20a. Method of Disposition AUGUST 15 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE, MARYLAND 2008 21. Signature of Functal Service L 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumone > 5day /Medical Du lo (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury) that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-tran and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical Attending Physician: The law requires that the death certificate the as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) signed by the a 1 🗆 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Nown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an tensio has autopsy performed? certificate Carcinsina 2 **So**No 1 ☐ Yes 2 ☐ No 1 🗆 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **X**No 1 inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Alatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Hospital or Attend 24 hours after death Funeral Director: 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 8-11-2008 1) 24804

DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peterson

rar's Signature

Annegolis MD

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7:30 AM AUGUST 2008 NANCY HENRIETTA FRAZIER 11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner QUEEN ANNE'S 308 QUEEN ANNE ROAD **STEVENSVILLE** 8. Date of Birth (Month, Day, Year) OCTOBER 26,1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Months Days Hours 1 □ M 2 X F 216-36-9083 83 **ENGLAND** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 X No Director MARYLAND QUEEN ANNE'S STEVENSVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 308 QUEEN ANNE ROAD UNITED STATES 21666 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 X No ð 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BANK TELLER BANKING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WALTER STROUD DAISY MARWOOD ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 QUEEN ANNE ROAD, STEVENSVILLE, MARYLAND 21666 FRANK S. FRAZIER, JR/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition AUGUST 14 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 2008 STEVENSVILLE, MARYLAND 21. Signal re of uneral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the disease, or complications that a sed the death. shock, or heart failure. List only one cause in e. ch line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) can. schemic Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

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Box 68760

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Records,

Division or Vital

Hospital or Attending

**Funeral** 

Director

28a-f show be notified at

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s 1 and 2 should be filed wi f Health and Mental Hygien item 27 is marked other th

**Examiner** must

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Baltimore,

physician and the burial-transit attending for use ed by the a detached f signed k peen certificate has page 2 director,

Examine Physician/Medical 9 Completed Be မ Certification:

After t death. 24 hours after death e Funeral Director:

the the within 7 ۵

24a. Was an

1☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 ER/Outpatient 3 DOA

28b. Time of

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☑No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

32036

29d. Date signed (Month, Day, Year)

30. Name and address of person with completed cause of death (Item 23a) (Type, Print)

108 D. Warb 31. Date filed (Month

AUG 2008 13

1 Inpatient

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** BNK /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death **Examiner** 3 gen 5. Social Security Number 6. Sex If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birtho **Funeral 1** M 2□ F 196-05-4555 93 June T915 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It is required. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1XXes 2□No Berks Pennsylvania Reading 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 934 N. 4 th Street United States 19601 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1942-∏Yes 2 □ No Yes, Give 1 ☐ Never Married 2 ☐ Married 21215-0036 1 □Yes 2 XXo Specify: Specify: White ģ 1946 XXWidowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Upholsterer Services Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert Frank Margaret Reusing 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith C. Bachman / Daughter 1909 Beeches Glory Path Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial XXX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 9/11/2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. Mich 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 50 disease or condition resulting in death) TID /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۵ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 2 R/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospital within 24 hours a To the Funeral C Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed, (Month,, Day, Year) 114 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) illiAm ONES Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 1 2008 Registrar

State of Maryland / Department of Health and Mental Hygien 2 0 0 8

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		•	For State of Wal yland / Department of State of Wal yland / Department of Certificate of Registrar			Reg. No.	) 21402
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1	Examin	er		, or Location of Death		4c. County of De	
		2.	Casey House Montgomery Hospice Rockvi  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea		8. Date of Birtl	Montgo	
الله الله الله الله الله الله الله الله	Funeral Director		213-90-0506  Usual Residence of Decedent		SEP 17,	, Year) 1927 Ir	Birthplace (State or Foreign Country) an
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	the N	ect	Maryland Montgomery Rockville  10e. Street and Number 10f. Zip Code			10g. Citizen of What	Country?
	with a or t be r	Funeral Director	14401 Traville Garden Circle, #303 20850			United S	
	ms 2:	Jera	11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of	f Hispanic Origin? (Spo uban, Mexican, Puerto	ecify Yes or No-		merican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	Armed Forces?   If Yes, specify Control   If		Hican, etc.)	Black, W	•
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Maryland	shoule nd Me mark imatie	=	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Stre	 et and Number or Rur	al Route Numbe	er, City or Town, State	e, Zip Code)
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Baltimore,	permit. Departr Importa any inju		21. Signature of Funeral Service Vicensee M00956 22. Name and Add Thibadea 933 Gist	ress of Facility Lu Mortuary Lave., LL,	Service Silver	e, P.A.	MD 20910
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	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
200	Examine	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
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.O. Box	death ce e attendir d for use	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)			23d. Date of Month	delivery Day Year
S, P	s that ned b e deta	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.	23e. Did to	obacco use contribute	e to the cause of death?
rds	quire; in sig	q p			1 🗆 🗅	Yes 2 No 3 □	Probably 4 Tunknown
Record	e far has le 2	Completed		11 (m) 11 (m) 1 (m	24a. Was autor perfo 1 Yes		
Vital	(Q hall	Be C	25. Was case referred to medical examiner?	26. Place of Deat		no)	ICE FACILITY
or V	Physiclan: r this certific ral director,	To	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA		ome 5 🗆 Resid		pecify)
n o	dIng Physiclan: After this certific funeral director,		27. Manner of Death 1 ⚠ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury V		28d. Describe I	how injury occurred	
Division	Attending r death. sctor: After y the fune	Certification:	3 Suicide 6 Could not be 289 Place of injury. At home farm street factory office	☐ Yes 2 ☐ No	29f Location (6	Strant and Number of	Rural Route Number,
<u>&gt;</u>	lor A after Direction by	ertif	4 Homicide determined building, etc. (Specify)		City or Tox	vn, State)	nural notice Number,
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the	time, date and place,	and due to the	cause(s) and manne	r as stated.
	n 24 ł	Medical	(Check only pedical Examiner: On the basis of examination and/or investigation, in mone) Medical Examiner: On the basis of examination and/or investigation, in mone)	y opinion, death occur	rred at the time,	date and place, and	due to the cause(s)
P	within To the comp	Me	()	ense number		29d. Date signed (M	
) [	4		Deniene Wholder SK'no DO	0064615		AUGUST 7,	2008
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
			Genevieve A. Wroblewski, M.D., 6001 Muncaste	r Mill Roa	d, Rock	ville, MD	20855
September 1	Sta Registi		31. Date filed (Month, Day, Year)  AUG 1 1 2008  32. Registrar's Signature				

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

_			1 - State of Maryland / Dep	rtificate of Death	, ,	g. No. 2008	27463		
	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year	3. Time of Death		
weeps,	/Medic		Clyde Robert Gingrich  4a. Facility Name (If not institution, give street and number)	August	4, 2008 4c. County of Death	2:47 A <sup>M</sup>			
تمميد	Exami	eı	Anne Arundel Medical Center		Anne Arun	del			
Т	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Annapolis    If Under 1 Year   If Under 24 Hrs.     Months   Days   Hours   Min.	8. Date of Birth (Month, Day,		lace (State or Foreign itry)		
	Director		578-22-7235 XX 2 F 83 Yrs.  Usual Residence of Decedent		Mar 1, 1	.925   Kansa	as		
	yland now		10a. State 10b. County 10c. City, Town or Lo	ocation		11	0d. Inside City Limits		
	a-fst	ctor	Maryland Anne Arundel Annapoli	S			1 □Yes 2□No		
	or 28	Directo	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coun			
	s 23a	eral	85 Manresa Drive	21409		Inited State			
0	fter de r item direct	Funeral	1 Never Married 2√17 Married   1√17√Yes 2 No 1 ∩ 7.2	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Americ Black, White, e			
93	ral",o	by	3 Widowed 4 Divorced If ₩S, Give 1943 Ye ar or Dates: 1946	1 □ Yes 2√√No Specify:		Specify: Wh:	ite		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examinat must be redified at	Completed	15. Decedent's Education 16a. Dece	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 10	6b. Kind of Business/Inc	dustry		
2	within iene. than	duic	Elementary/Secondary (U-12)   College (1-40r 5+)	DO NOT use retired)		Master Ele	octrician		
	il Hygi other	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		ectrician		
<u>lar</u>	should be filed within 72 hours after death with the Marylan and Mental Hygiene. In marked other than "natural", or items 23a or 28a-f show immatic event, the Medical Examinations be notified at	TO E	BertGingrich	Henrietta	a Yoch		:		
Maryland	2 S S S S S S S S S S S S S S S S S S S	7.3		ng Address (Street and Number or Rui			Code)		
	1 and Heal em 2 ther			Drury Lane Dunkin					
nor	Pages nent of int: If Its iry or o			osition (Name of matory or other place) e Crematory 8/11,	.   -	oc. Location - City or To Saltimore, N			
Baltimore,	permit. Pages Department of Important: If I any Injury or once.			2. Name and Address of Facility Joi					
ñ	any per			47 Duke of Glouces					
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between		
4	Physician	8 7	Immediate Cause (Final disease or condition resulting in death)  a. Respire for years and the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of t	rrest			Onset and Death		
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		Physician/N	1 Yes 2 No 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year		
<b>7</b> .	hat th ed by 1 detach		9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the L	nderlying gauge given in Port I	220 Did tobo	acco use contribute to the	an acuse of death?		
ecords,	law requires that the as been signed by the 2 should be detache	d by	Coronary Artery disease	inderlying cause given in Part I,		2 No 3 Prob			
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Y	The Is ate ha	Completed		+ failure	autopsy performe	prior to cor death?	npletion of cause of		
Vital	clan; ertific ector, j	Be	25. Was case ferred to medical examiner?		(Check only one)		Z ISINO		
_	Physician; r this certific ral director, I	မ	1 ☐ Yes 2 ☐ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie  27. Manner of Death  28a. Date of Injury 28b. Time of Section 1.			ce 6 Other (Specify	y)		
5	iding th. : After : funer	tion	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury	f 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how	injury occurred			
UNISION	Atten er dea' ector by the	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Stre	eet and Number or Rura	l Route Number,		
5	ital or rrs afte ral Dir led in	Cert			City or Town,				
	To the Hospital or Attending P within 24 hours after death.  To the Funeral Director: After t completely filled in by the funera	Medical	29a. Certifier  (Check only one)  (Check only one)  (Check only one)	th occurred at the time, date and place, westigation, in my opinion, death occur	and due to the car red at the time, dat	use(s) and manner as s te and place, and due to	tated. the cause(s)		
	To the within To the compl	Me	29b. Signature and title of certifier	29c. License number	296	d. Date signed (Month,	Day, Year)		
	,		James Vannihum	DC 25499		8/7/08			
	112/		30. Name and address of person who completed cause of death (Item 23a) (Type,		.1	1 /			
	Sta	e	JAmes Vyne 1460 R 31. Date filed (Month, Day, Year) 32 Rajistrar's Signature	itchie Highw	ay A	-rnold, mi	21012		
	Registra		AUG 1 1 2008 Region &	and a					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 24a per dr., 8892, 06726/09dhb Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Betty Mae Harmon August 8 2008 12:05 a.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chesapeake Woods Center Dorchester Cambridge If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F 80 Director 213-22-8392 Nov. 16, 1927 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow if item 27 is marked other than "natural", or items 23a or 28s-f show or other traumatic event, the Medical Examinar must be notified at 1 TYYes 2 □ No Completed by Funeral Director MD Dorchester Cambridge 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 316 Bayly Avenue 21613 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after t Depertment of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Ites any injury or other traumatic event, the Medical Examin 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) retail supervisor 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nettie Warfield Walter D. Jones 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 315 Bayly Ave., Cambridge, MD Joyce Wheatley daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State 8/11/08 Cambridge, MD Dorchester Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Ameral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. (i Lonn 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** heart congestive lo months /Medical Due to (or as a consequence of): Examiner Cardiomyo patt Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Clostridium difficile diarrhea 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2**X** No 1 ☐ Yes 2 ☐ No al or Attending Physician: T s after death. It Director: After this certificat of in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours aft To the Funerel Di completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number HO0 59973 30. Name and address of person who completed cause of death (Ilem 23a) (Type, Print)
P Johason 100 Bramble St Cambridge MD Johldso

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month,

strar's Signature

2 2008<sup>32. Rd</sup>

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ian cal	. Decedent's Name (First, Middle	. ,	homas Hit	chins					2. Date of De Month AUGUS	Day	Year 2008	3. Time of 12:5	
ner 4	a. Facility Name (If not institution WMHS - MEMORIA)		imber)			y, Town, or t		of Death		4c. (	County of Death		
	Social Security Number 213–18–2672	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. 87		Months	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da		Co	nplace (State o untry) Mary la	
11	Isual Residence of Decedent  Oa. State 10b. County  Maryland	Allegany	10c. City	y, Town or	Location		Fros	stburg	r			10d. Inside Cit	
<u> </u>	0e. Street and Number	05 Carlos Ro	ad SW		10f. Z	ip Code	21	532				USA	
by Fur	1. Marital Status 1 □ Never Married 2 🕱 Marri 3 □ Widowed 4 □ Divorced	Armed F	2 ☐ No ive	.S. 1		-	spanic Ori n, Mexicar Specify:		pecify Yes or No Pican, etc.)		14. Race - Ame Black, White Specify:		te
Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)	st grade completed)	1-4or 5+)	(G	ecedent's Us live kind of v le. DO NOT	vork done du	<i>uring m</i> os		king	16b. Kir	of Business/		
To Be Co	7. Father's Name ( <i>First, Middle,</i>		0 Iitchins				Min 18. Mothe		e (First, Middle,	_		Company	/
	19a. Informant's Name/Relationsl Melody	nip (Type. Print) Fink- Daught	er	19b. M	ailing Addre				ral Route Numb SW, Cumb				
2	0a. Method of Disposition  1 ☑ Bunal 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S			emetery, o	sposition (Norematory of unset Me	r other place			Date August 14, 2008	20c. Lo	cation - City or Cumberla	Town, State and, Mary	land
2	21. Signature of Funeral Service	Licensee	om		22. Name	and Address			Eichhe Street Lon		cKenzie Fi g, MD 215		ne P.A
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Ž Z	29b. Signature and title of certifie		/		2	9c. License	number		·	29d. Dat	e signed (Mont	h, Day, Year)	n0
	30. Name and address of person		use of death (Item					MDET	OT AND N	M 21	SUST	15 de	UX_

State Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

08-06293 Raymond Rainer Johnsor Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend State of Many and Department of Many Mental Hygiene

2008 27466

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29b. Signature and title of certifier  O.C.M.E. August 17, 2008  30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner  111 Penn Street, Baltimpre, MD 21201  State 31. Date filed (Month, Day, Year)  Registrar's Signature	of of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of or of	funera				l	FOUND:	ay,Year)	FOUND	<b>)</b> :	1							
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29b. Signature and title of certifier  O.C.M.E. August 17, 2008  30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner  111 Penn Street, Baltimpre, MD 21201  State 31. Date filed (Month, Day, Year)  Registrar's Signature	ivis Ilor A	.E			deterr	not be nined	(Specify)	Backy Other (s	ard of	resid	lenc	e		11 Bald	win Circ	ile, Abero	leen, M	D
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29b. Signature and title of certifier  O.C.M.E. August 17, 2008  30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner  111 Penn Street, Baltimpre, MD 21201  State 31. Date filed (Month, Day, Year)  Registrar's Signature	the II. 1 in 24 1 the Fu	nplete	lica	(Check only one) 2	✓ Medical Exam	niner: On	the basis of	examinatio	n and/or inve	stigation, in	my opii	IIOII, ueau	00001100	at the time	e, date a			
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4.	. Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Dav	3. Time of Death	
	/Medic	al -	William Clatty Klo  4a. Facility Name (If not institution, give si			4b. City, Town, or	Location of Death	August	4c. County		
43	Examin	er	2543 Cove Rd.	reet and number)		Accident			Garr		
); ();	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. la	Ven	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	<sup>Year)</sup> 1931	9. Birthplace (State or Foreign Country) Pennsylvania	
	טי		Usual Residence of Decedent		, Town or Lo	antion				10d. Inside City Limits	
	laryla shov	5	10a. State 10b. County		ident	Cation				1 ☐ Yes 2 <b>½</b> No	
	28a-1	Director	MD Garrett  10e. Street and Number	ACC	raeuc	10f. Zip Code		10	g. Citizen of V	What Country?	
	h with		2543 Cove Rd.			21520			USA		
36	Juithin 72 hours after death with the Maryland plans and retain a returner, or items 23s or 28s-f show it has negliged at the most be notified at the Maryles Examiner must be notified at	by Funeral		2. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 D.No If Yes, Give Korean Year or Dates: War		Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Sin, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		e - American Indian, ck, White, etc. y: White	
Š	2 hou		15. Decedent's Educ	ation	16a. Dece	ient's Usual Occupa	ition			usiness/Industry	
21215-0036	within 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired,			of Edu	t County Board	
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and	B E D	To Be	John Elsworth Klot	zbaugh			Mabel Ha	arriet Wo	oster		
Maryland	de la la	F	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (Street a				State, Zip Code)	
	1 and 2 s Health ar Iom 27 is		Diane M. Klotzbaugh			Cove Rd.	, Accide		1520		
altimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	moval from State	metery, cre	sition (Name of matory or other place	1	V.855		City or Town, State	
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Bal	Depar Impor any ir		21. Signature of Funeyard Service Licence  23a. Part 1. Enter the disease, or complice	euna	]	P.O. Box	275, Gra	ntsville,	MD 2	mes, P.A. 1536	
8760,	hysician hysician and hysician and hysician and hysician and the prinai-transit	al Examiner	Shock, or head tallure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	v F vence of):	esopho				Interval Between onset and Death onset and Death of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of the Michael of	
P.O. Box 687	ne death certific the attending p thed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	ac. If yes, outcome of pregnar 1 ∐Live birth 2 ∏ Fetal 4 ∏ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)	700			ate of delivery onth Day Year	
	juires thet the signed by ald be detact	b	Part II. Other significant conditions con	tnbuting to death but not resu	ulting in the u	inderlying cause give	en in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 NO 3 Probably 4 Unknown			
Il Records,	The ete h page	Completed								Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		oth	00	ath (Check only on			
of	sing Phys	atlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	at 28c. Injun	4 🗀 Nul Sing 1	28d. Describe ho				
Division	P dig ⊆	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, st	reet, factory, office		28f. Location (St. City or Town	reet and Numi n, State)	ber or Rural Route Number,	
	To the Hospitel within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier 1 Certifying Physical Control 2 Medical Exemination	sician: To the best of my kno- ner: On the basis of examinal and manner stated.							
	To the Youthin Comp	& Me	29b. Signature and title of certifier	Manu	11)	29c. Licens	e number	759 2	9d. Date signed Aug 1	ed (Month. Day, Year)	
		HU	11 1-	mpleted cause of death (Item	23a) (Type	Print) 5 old	Engle	Mill Rd.	Aci	ed (Month, Day, Year)  US 7 13, 2018  US 4 MD	
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	Andrew 1	<i>y</i> •				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 9, 2008 Month **Physician** August 6:00 aM Phil Carr Longenecker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice-Casey House Rockville Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days Hours Min Months 1 32 M 2 □ F Director 578-30-5728 Sept. 24. 1928 Washington. Usual Residence of Decedent be filed within 72 hours after death with the Maryland ntal Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2√ No Director Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 4703 Wyaconda Road 20852 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Never Married 2 ₩ Married White 1 ∐ Yes 2 MiNo Specify: þ Specify: 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Photographer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) if Health and Mental Russell S. Longenecker Edna M. Carr ၉ Pages 1 and 2 should nent of Health and Mer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other t Patricia G. Longenecker/ Wife 4703 Wyaconda Road, Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Department of Important: If it any Injury or conce. 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Aug. 14 Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2008 Rockville, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W,. Silver Spring, MD 20901 amser Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Lymphoma

Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) been signed by the a should be detached to 1 Tyes 2 TNo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Tes 2 No 3 Probably 4 thunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 □Yes 2 No 2 To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 QOther (Specify) Hospice 1 Yes 2K No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending investigation ours after death.

neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide thin 24 hours a 29a. Certifier 怪Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marrier stated.

3altimore, Maryland 21215-0036

P.O. I

of Vital

State Registrar

Month, Day, Year) 31. Date filed (Mg 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier





29c. License number D64615

29d. Date signed (Month, Day, Year)

August 9, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Vargot 2008 Ana 7:55 AM /Medical 4b. City, Town, or ocation of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner Genesis HealthCare The Pines Talbot Ėaston 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours Days Months Director Mary/and Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ns 23a or 28a-f show must be notifled at 1 Tes 2 No Funeral Director Talboi rappe 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian, . Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 No Specify Specify. Completed by Black 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) is marked other than "natur aumatic event, the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Someone else's home 10 Domestic Work 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be daney Sr. 05510 ilveste Mae tarnis ۴ 19b. Matth), Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Important: If Item 27 is any injury or other trai once. P. O. BOX 11 ethlehem Department of Health Maryland onda 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Bernoval from State Pemetery 8/15/08 Laston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) offers Ville 22. Name and Address of Ficility 21. Signature of Funeral Service Licenses Funeral Home, P. 23a. Part. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cámbridge, MD, 21613 Approximate Interval Between Onset and Death Immediate Cause (Final DISSECTION **Physician** AORTIC )EEKS disease or condition resulting in death) /Medical Due to (or as a consequence of): IVER Examiner Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 Ves 2 No 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of performed? Yes 2 No death? 1 ☐ Yes this certificate 2□No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Man er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 5 ☐ Pending investigation within 24 hours after upcom.

To the Funeral Director: After the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of t 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 32. Redistrar's Signature

ROWLEY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 MOlock Maga /Medical MMa 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner ambridge GENERAL Dorch Dorchester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs, last birthday) **Funeral** 1 □ M 2 1 F Months Days Hours Min 220-01-289 Usual Residence of Decedent 6 220-01-Director Marylano 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ₺No MD Director bridg 10e. Street and Number 10g. Citizen of What Country? US. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seafood Indu permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 Is marked other 1 and 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Davis ည ttie or other traumatic a ar Nutter Mary 19a. Informant's Nao e/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin Franklin Molock 4984 Drawbridge Raad Cambrida

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location Journal of Cemetery, crematory or other place) MD.21613 Baltimore, 20c. Location City 1 Burial 2 □ Cremation 3 □ Removal from State Cemetery 8/16/08 Cambridge Injury 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address | Facility | Henry Funeral Home, P. A. |

23a. Papt. Enter the disease, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, |

Immediate Cause (Final) MD21613 Approximate Interval Between Onset and Death immediate Cause (Final cerebral Vascular acciden Physician monte disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ha Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate | 1□ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation Hospital or Attending 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. To the 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Johnson, D.O., 100 Bramble Street, Cambridge, MD 31. Date filed (Month, Day, Year) AUG 1 3 2008 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend 26 per phys, DOR, Certificate of Death 1. Decedent's Name (First, Mittale, Bast) 2. Date of Death Year Month **Physician** 2008 Victor Allen Melvin 8 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 3622 Meadow Bridge Road WILLOMICO 8. Date of Birth (Month, Day, Ye. Jan. 12, Year)
, 1960

9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Unde **Funeral** Days Hours 1 X M 2 □ F Months 48 212-78-3605 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County id 2 should be filed within 72 hours after death with the Marylar lith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Eventhan must be notified at 1 ☐ Yes 2 No Funeral Director DE Sussex Rehoboth Beach 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19971 USA 103 Norwood Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 ☒No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐Yes 2 No If Yes, Give Year or Dates: Specify. þ Specify. White 3 Widowed 4 N Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Merchandiser Beverage Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental John William Melvin Sue Todd ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra 103 Norwood Street, Rehoboth Beach, DE 19971 Chelsea Purnell/Former Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8/4/2008 Crematory of Delmarva Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Line 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, MD 21802 Approximate Interval Between Onset and Death Rart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIOMYOPA **Physician** STAUE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner One to (or as a consequence of) Physician: The law requires that the death certificate be executed Exami and Due to (or as a consequence of): attending physician (for use as the burlal) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) ☐Yes 2 ☐No P.0. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? certificate 1 ∐Yes 2 TNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 6 Other (Specify residence 1 ☐ Yes 2 ☐ 110 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Director: After th 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Hospital or Attending 1/2 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by within 24 hours after To the Funeral Direct 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Continued in the cause | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physi 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0005 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. O D. x 1733 SACIS BULLY UND 21852

DHMH 17 Rev 1/2001

State Registrar Co Huisam

31. Date filed (Month

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gistrar's Signature

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2008 Alberta June August 12 1445 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Garrett Garrett County Memorial Hospital 0akland If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
June 28, 1934

9. Birthplace (State or Fo. Country)
Pennsylvania Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 X F Director 168-28-5462 Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral', or itema 23a or 28a-f show Examinar roust be notified at 1 ☐ Yes X☐ No Director PA Allegheny Pittsburgh 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 53 Hempstead Avenue 15229 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify. δ 3X Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within 7:
Department of Heelth and Mental Hygiene.
Importent: If item 27 is marked other than "ne any injury or other treumatic avent, the Middle 2006. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Albert Boehm Margaret Lowdermilk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 Oxbridge Drive, Pittsburgh, PA Judith Pavlot, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/16/2008 St. Mary's Mt. Troy Pittsburgh, PA David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 21550 21. Signature of Funeral Service Licensee Katherine Dweite 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and the for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by the should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 N 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ Inpatient 2 ER/Outpatient 3□ DOA this To the Funeral Diractor: After thi completaly filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Natural 5 Pending investigation death. 1 Tyes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours efter To the Funeral Dira 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D23979 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Robert Goralski, Α. 311 N. Fourth Street, Oakland, MD 31. Date filed (Month, Day, Year) AUG 1 4 32. Registrar's Signature State 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 5<u>,</u> 12:30 PM LORETTA AUG. 2008 ANNE RUCKER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL MONTGOMERY TAKOMA PARK If Under 1 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕅 F Director 579-36-9973 WASH. D.C. 80 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " " " " " " " " any Injury or other trainment." 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 TYYes 2 □ No Director MD. MONTGOMERY TAKOMA PARK 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 807 COLBY AVE. 20912 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 1 No
If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No þ Specify 3 ₩ Widowed 4 Divorced Year or Dates: BLACK Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED NURSE N.I.H. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ LUCAS DANIEL BARRY JULIA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARRY/SISTER 807 COLBY AVE., TAKOMA PARK, MD. 20912 JANET 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 8-13-2008 LINCOLN MEM. CEM. SUITLAND, MD. 21. Signature of Funeral Service Lipensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A 5801 CLEVELAND AVE., RIVERDALE, MD. M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examiner consequence of): bsy the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a donsequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed? Yes 2 No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 1 Natural
2 ☐ Accident (Month, Day, Year) 5 Pending s after death.

I Director: Al 1 ☐ Yes 2 ☐ No investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOBARAK 12ARIM, 7610 CARROLL AVE, STE340, TAKOMA PARK 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar DHMH 17 Rev 1/2001 AUG 11

P.O. Box 68760

William of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Marian Irene Riesberg August 10 2008 09:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 41 Brownfield Loop E1kton Ceci1 If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X E Director 163-03-4294 96 Dec. 10, 1911 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10d Inside City Limits Director 1 ☐ Yes 2 X No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41 Brownfield Loop United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. I important: If Item 27 is marked other than "natural" or New any Injury or other trainments. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert Trumbauer Mary Estella Naudascher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Parsio / Daughter Brownfield Loop, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 14. XXBurial 2 □ Cremation 3 □ Removal from State Quakertown Pennsylvania Union Cemetery 5 ☐ Other (Specify) 2008 21. Signature of Fundal Service License 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disea e, or complication that caused the death. Do not enter the mode of dying, such as circlindrated respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician unknown 10, /Medical or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or se a consecuence of) Due to (or as a consequence of): Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ó in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performe 20 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natura! 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 the or Attending Physician: this s after death. filled in by the within 24 hours a To the Funeral C

21215-0036

Maryland

Baltimore,

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) AUG 1 3 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2008 Year **Physician** August 6, Ernest Ray Shelton, Jr. 11:28 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours 1 3 M 2 D F Virginia 73 Feb. 4, 1935 Director 227-42-4763 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. Cify, Town or Location show 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 Tv No Director Prince George's Silver Spring Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 20903 USA 8310 12th Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ➡ No 2 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Small Business Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Susie Jordan ၉ Ernest Ray Shelton, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Harriet S. Shelton/Wife 8310 12th Avenue, Silver Spring, MD 20903 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🏖 Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd., W. Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due of or as a consequence of): Cardiovascular **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner bue to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐Yes 2 XNo 1 ☐ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in I n 24 hours a 29a. Certifier TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tiple of cer D057692 August 10 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7701 Carroll Avenue, Takoma Park, MD 20912 Drewry James White, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 11 2008 Registrar AUG

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

2008 27476

			1- For State Certificate	of Death	Reg. No.	2000 2141
F	hysici	an/	Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
" al	Exami	ner	James Claude Sands		Month Day Ye August 5, 2008	1140 hrs
			4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deatl		
			12530 Great Park Circle Apt 102	Germantown	Montgo	
	uneral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	) If Under 1 Year   If Under 24Hn Months Days Hours Mir		
וט	rector	- 1	219-64-4192   1X <sub>M</sub> 2 F 54	Yrs.	FEB 23, 1954	Foreign Country) France
	À		Usual Residence of Decedent		'	10d Isside City Limite
	w any		10a. State 10b. County 10c. City, Town or L  Maryland Montgomery Germanto			10d. Inside City Limits  1 Yes 2 X No
and	r sho	ġ				
N N	r 28a ed at	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of V	·
th the	23a o notifi		12530 Great Park Circle, #102	20876		States
<del>1</del>	ems it be	Funeral	1 X Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto		ce - American Indian, Black, lite, etc.
Pr des	or in	Fu	1 Yes 2 A No	Voc. 2 W No. openits	Saco if	« III : -
- S	ural' mine	by	Lor Dates:	Yes 2 X No specify: edent's Usual Occupation (Give kind of	work done 16b. Kind of I	White
, hou	"nat	ted	Elementary/Secondary (0-12) College (1-4 or 5+)	g most of working life. DO NOT use re		,
)36 hin 7	than edica	Jdu	12 None	<u>.</u>	None	
00	lygier other he M	Completed by	17. Father's Name (First, Middle, Last)	18.Mother's Nam	e (First, Middle, Maiden Surnan	ne)
215	rked	Be	(Unavailable)	Chistia	le (First, Middle, Maiden Surnan Ne ne Marie Sohne	r
21	d Me is ma tic ev	70		ailing Address (Street and Number or		
, MD 21215-0036	men of Health and Mental Hygiene. fant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.			Musket Ball Dr,. C		0
ē,	f Hez		1 Burial 2 V Cremation 3 Removal from State crematory	sposition (Name of cemetery, or other place)		n - City or Town, State
imo	ant:		4 Donation 5 Other Specify: Riverda	·	/09/2008  River	
Baltimore, MD 21215-0036	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Thibadeau Mortua	rv Service. P.	Α.
			11 11 11 11 11	933 Gist Ave., L	L, Silver Spri	ng, MD 20910
	/sician ledical		23a. Part I. Enter the disease, or complications that caused the death. Do not enfailure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest, shock, or i	Between Onset and
	miner		Immediate Cause (Final disease or condition resulting in death)			Death
			b back to (or as a consequence or).			
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	_	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated expents resulting in death.) East  Due to (or as a consequence of):			
3	d ansit		events resulting in death) Last  Due to (or as a consequence of):  d.			
760,	physician and the burial - transit	Medical				
760,	hysici e buri	Med	UNPENDED #MENDED #18perFH 8-11-08,PW,N  IF FEMALE: 23c. If yes, outcome of pregnancy	/b0b	23d. Date	of delivery
687	ling p		23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregr		1
Box (	ned by the attending detached for use as t	Physician/	Pregnant at time of death 5	Other (Specify)		1
	y the	F	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I	23e Did tobacco use co	ntribute to the cause of death?
O	has been signed by 2 should be detach	þ	Contributing to doubt but not receiving in	are directlying decode given in any i.		3 Probably 4 ✔ Unknown
ds,	sen sig	Completed			24a. Was an 24i	p. Were autopsy findings available
Sor	has be	l du			autopsy performed?	prior to completion of cause of death?
Records,	icate page	S			1 ✔ Yes 2 No	1 🗸 Yes 2 No
ta j	certi	å	25. Was case referred to medical examiner? Hospital: 1 Innatient 2 FR/Outnatient 2 FR/Outnatie	26.Place of Death (Chec		
of Vital	er this ral dire	유	1 V Yes 2 No	e of Injury 28c. Injury at Work?	sing Home 5 Residence 6	Other: Scene
	eath.  ior: After this certif the funeral director,	<u></u>	1 Natural 5 Pending FOUND: Day, Year) FOUND	Yes 2 ✓ No	Subject became wedg	ed between wheelchair
isio	r deal	cat	2 Accident Investigation Aug 5, 2008 1130 hr	s	and bed	mber or Rural Route Number, City
Division	ours after derail Direct	Certification:	determined (Specific) Cingle Comity	out dot, reasony, amos bunding, ato.	or Town, State)	apartment 102, Germantown,
0	24 hou Franer stely fil		29a. Certifier	occurred at the time, date and place, ar	1	
P	within 24 hours after death  To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or inve			
		Me	29b. Signature and title of certifier	29c. License number	29d. Date s	igned (Month, Day, Year)
	3		The 111 His To	O.C.M.E. 0	CME August 6	3, 2008
			30. Name and address of person who completed cause of death (Item 23a)			
			Theodore M. King, Jr., MD. Assistant Medical Examine	r 111 Penn Street, Baltimo	ore, MD 21201	
	S	tate	31. Date filed (Month, Pay, Year) 2008 32. Registrar's Signature	Mar. 16		

			For State Registrar		State of	f Marylan				lealth <i>Death</i>		ental Hy	gien Reg. No	e .200	8	274	.77
	Physici /Medic		1. Decedent's Nam Grace So	ne (First, Middle, La: tomayor	st)							2. Date of De Month August	_ Da	°, 2008°	ır	3. Time of D 12:00	
1	Examin		14705 Se	ilf not institution, giv neca Cast				Nort	h Po	r Location COMAC				c. County of De			
ì	Funeral Director		5. Social Security N 217-70-6	753 ¹	ex □M 2XXF	7. Age (In yrs.	87 Yrs.	Month:	er 1 Year S Days	If Under Hours	Min.	8. Date of Bir Jan 19	th ay, Year	921 Ch	Birthpla Counti	ace (State or	Foreign
	/aryland f show	ō	Usual Residence of 10a. State	10b. County	~~·		y, Town or Lo								100	d. Inside City	
:	n with the I	Funeral Director	10e. Street and Nu	Montgome <sup>mber</sup> neca Cast			11 1000		ip Code				10g. C	itizen of What	Countr		A
950	rs after dea l", or items	by Funer	11. Marital Status 1 □ Never Mari	ried 2 Married	12. Was Dece Armed For 1 ∐Yes If Yes, Giv Year or Da	/e		Was Dec If Yes, sp 1 □Yes		lispanic Or an, Mexica Specify		cify Yes or No Rican, etc.)	)-	14. Race - Ar Black, WI		C.	
212-0030	be flied within 72 hours after death with the Maryland tal Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed		15. Decedent's Ecify only highest gra	l lucation		life.	kind of w DO NOT	ork done use retire	durina mos	st of workir	ng		Kind of Busines			
		To Be Col	17. Father's Name	(First, Middle, Last) Atkey			Homen	naker				(First, Middle	, Maidei	n Home			
, Mary	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evonce.	F	19a. Informant's N Katherin	ame/Relationship ( e Sotomay	Type. Print) or/daug	hter	19b. Maili 14705	ng Addre Sen	ss (Street IECA (	and Numb Castl	er or Rura e Cou	I Route Numb Irt N.	er, City Poto	or Town, State	e, <i>zip (</i> D 2	20878	
altimore	. Pages 1 at the trant: If item jury or oth		4 □ Donation	Cremation 3 5 Other (Specif	y)	C	Place of Disponentery, cre sapeak	matory`or ce Cr	other place emate	ory	08/13		Belt	ocation - City	, M	D _	
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	hysician /Medical		shock, or heat immediate Cause disease or condition resulting in death)	on	a. Pneum	onia		iter the m	ode of dyli	ng, such as	s cardiac o	r respiratory a	irrest,			Approximate Interval Betwo Onset and De	een
E	Examiner	Jer	Sequentially list co	enditions, nmediate	ь Cellu	or as a consequent of as a consequent of as a consequent of as a consequent of as a consequent of as a consequent of as a consequent of as a consequent of as a consequent of as a consequent of as a consequent of as a consequent of as a consequent of as a consequent of as a consequent of as a consequent of as a consequent of as a consequent of as a consequent of as a consequent of a consequent of as a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent of a consequent											
o/ oU,	To the mospital or administrate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	ıl Examiner	Sequentially list co if any, leading to in cause. Enter Und Cause (Disease or that initiated event resulting in death)	injury s Last	Due to (	tension	uence of):	D:			-	<del></del>					
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DI VIII	his certif	To Be	25. Was case reference examiner?  1 Yes 2		Hospital: 1 ☐ I	npatient 2	ER/Outpatie	nt 3 🗆 [		er: 4 🗆 N		(Check only only only only only only only only		6 ☐ Other (S	pecify)	)	
	death. stor: After I	Certification:	27. Manner of Dea:  1 X Natural  2 □ Accident  3 □ Suicide	5 ☐ Pending investigation 6 ☐ Could not be		of Injury h, Day, Year) of Injury - At ho	28b. Time of Injury	M		yat k? Yes 2□	lNo	8d. Describe		ury occurred	Durol	Pouto Numb	
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the Hoc	thin 24 h	Medical	(Check only one)	2☐ Medical Exar		asis of examina		nvestigation		opinion, de			date ar		lue to	the cause(s)	
٩	5 × × × ×		29b. Signature and	Lasen					6457					ust 11,			
7	100			ress of person who Naeem, M					ad R	ockvi	lle,	MD 208	350				
ĺ	Sta Registr		31. Date filed (Mor	nth, Day, Year) AUG 1 3	22 0	istrar's Signa	turo									_	

		,	1 _ State	State of Ma	aryland		rtment of H		/lental Hyg	giene	800	27478
_			Registrar  1. Decedent's Name (First, Middle, Last)						2. Date of Dea	ath		3. Time of Death
	Physicia		Constance Jean S	ullivan					August	: 11, 2	2008 <sup>ar</sup>	5:14 P M
	/Medic		4a. Facility Name (If not institution, give sa				4b. City, Town, or	Location of Death			nty of Death	
			6467 Beechfield Av	enue			Elkridge			Howa		
ı	uneral		5. Social Security Number 6. Sex	7. Ag		ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt Month, Da Mar 16	<sup>h</sup> <sup>Y</sup> 2 <sup>3</sup> 943	9. Birthr	place (State or Foreign prry) ington, D.C.
C	irector		579-54-2312 1□ Usual Residence of Decedent	W 22	65	Yrs.			Mar 10,	1343	Wasii	rigion, D.C.
land	MO W		10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits
Mary	i si	ģ	MD Howard		Laur	cel						1 □Yes 2√∑No
h the	r 288	ire	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cour	ntry?
death with the Maryland	23a c	Funeral Director	9406 N. Laurel Road				20723			USA		
	tems	nue	11. Maritar Status	2. Was Decedent Armed Forces?		S. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. F	Race - Americ Black, White,	
36 s afte	or I	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🄀 Divorced	1 ☐ Yes 21 I	No	1	□Yes 2 No	Specify:		Spe	cify: Whi	te
7215-0036 within 72 hours after	tural		15. Decedent's Educ	Year or Dates:		16a. Deced	lent's Usual Occup	ation			Business/In	
<b>51.</b> 72	n "na	blet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5		(Give life. L	kind of work done of OO NOT use retired	furing most of work  )	ring			
d with	glene er tha	Completed	10	College (1-40) C		Deli 1	lanager			Groce	cy Sto	re
and d be file	ital Hyglene. ed other than "natural", or Items 23a or 28a-f show event, the Modosi Examination uniber relified at	Be (	17. Father's Name (First, Middle, Last)					18. Mother's Nam			ame)	
aryla should t	n and Mental Hygien Is marked other th raumatic event, Inc.	မှ	George James Cross					Mary Ger				
ू क	S L		19a. Informant's Name/Relationship (Typ				g Address (Street					o Code)
<b>a</b> ,	of Health item 27   other tra		Tami Scovitch/daugh 20a. Method of Disposition	ter	20h P		Beechfiel		Date		on - City or To	own, State
Pages	t: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	Che	emetery, cren esapeal	sition (Name of natory or other plac Ke Cremat	orv 08/1	3/08	Beltsv	zille.	MD
altimor	= = =		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	0 //			Name and Addre					
Dalt permit.	Depar Impor any ir		13000 XH	ette	MO1	1251 B	ouerly I	Heckrot	te. P.A.	Clark	svill	e. MD 21029
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused								Approximate Interval Between
Ph	ysician		Immediate Cause (Final disease or condition				14 CANC					Onset and Death
	Medical		resulting in death)	Due to (or as			) 01110					
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peq	ısit	nine	Sequentially list conditions, if any, leading to hime diatacause. Enter Underlying Cause (Disease or injury	Due to (or as	a nonsequ	HONOG CE):						
<b>bU</b> , be executed	า and al-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as	a consequ	uence of):						
8/6U cate be	physician and s the burial-transit		L <sub>d</sub>									
587 tificate	ig phy as the	ledi	1. 1									
BOX b	tendir r use	an/N	23b. was decedent pregnant	Bc. If yes, outcome			Ectopic pregnanc	v		23d.	Date of deliv	
- e	the at red fo	Physician/Medical	in the past 12 months? 1 □ Yes 2\\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	4 ☐ Pregnant a 9 ☐ Unknown			Other (specify)	,			Month	Day Year
ords, P.O	d by letach	Ph	Part II. Other significant conditions cont	ributing to death h	ut not resu	ulting in the u	nderlying cause giv	en in Part I	23e. Did t	obacco use c	ontribute to t	the cause of death?
<b>Hecords,</b> ne law requires t	signe d be o	Completed by	DIABETES	g		3			1 🔯	Yes 2∐N	o 3 Pro	bably 4 Unknown
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The law	e has	g E							autoj perfo	rmed?	prior to co death?	ompletion of cause of
	tificat tor, pa	Be C	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes th (Check only o	2 [X]No   nne)		2 □No
ysici	iis cer direct	10 B	examiner? 1 ☐ Yes 2 ☑No	ospital: 1 🔲 Inpati	ent 2 🗆	ER/Outpatier	nt 3 DOA Oth	er: 4  Nursing H	ome 5 ☐ Resi	dence 6 🖔	Other (Speci	daughter's
n OT	fter th neral	l ii	27. Manner of Death 1	28a. Date of Inju (Month, Da	ıry ıy, Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe	how injury oc	curred	
SIOI endir	eath. or: A the fu	catic	2 Accident investigation					Yes 2 □ No				
DIVISION If or Attending	in by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At ho c. <i>(Specif</i> )	ome, farm, str y)	eet, factory, office		28f. Location (		ımber or Rur	ral Route Number,
pital	eral ceral era cera cera cera cera cera cera		29a. Certifier 1 Certifying Phys	ician: To the best	of my kno	wledge, deat	h occurred at the ti	me, date and place	and due to the	cause(s) and	d manner as	stated.
Hos	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	edical	(Check only 2 Medical Examinone)		of examina							
To th	To the	Me	29b. Signature and title of certifier	20	)	-	29c. Licens	e number		29d. Date sig		
			1 (2)	(1)1	-	L	1 14	4395	4	August	12, 2	8008
(D)	5		30. Name and address of person who con	mple cause of a	death (Item	n 23a) (Type,	Print) ARLES ST	8UTE 21	9 B	ALTIM	RE. M	1 21204
	Sta Registr		31. Date filed (Month, Day, Year) AUG 13 20	32. Registr	rar's Signa	ture	PARLES ST					

DHMH 17 Rev 1/2001

			For State	State of Mary					-/IIIIX	27479
			Registrar  1. Decedent's Name (First, Middle, Li	ast)		ertificate of	Deam	2 Date of Death	140	3. Time of Death
	Physicia /Medic		Yvette Denise S	·				August 9,	2008 Year	3:00 A M
	Examin		4a. Facility Name (If not institution, gi	ive street and number)			r Location of Death	1	4c. County of Death	
ego.			1305 Peaceful Lar.  5. Social Security Number 6.	Sex 7. Age (In	n yrs. last birthda	Silver S	If Under 24 Hrs.	8. Date of Birth	Montgomer	place (State or Foreign
	Funeral Director		213-58-7621	1□M 2\(\(\frac{1}{2}\) F	58 Yrs.	Months   Davs	Hours Min.	Aug 25, 1	949 Wash	ington, D.C
	and		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or	Location				10d. Inside City Limits
	Maryl a-f sho	tor	MD Montgome	rv S	Silver S	bring				1 □ Yes 2 No
	or 282	Direc	10e. Street and Number			10f. Zip Code			Citizen of What Cou	intry?
	eath w	Funeral Director	1305 Peaceful Lar	12. Was Decedent Ever	rin U.S. 1	20904 3. Was Decedent of I	Hispanic Origin? (S	Decify Yes or No-	14. Race - Amer	ican Indian,
٥	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Its Marical Examinar most be recilled at		<ul><li>11. Marital Status</li><li>1 □ Never Married _ 2 □ Married</li></ul>	Armed Forces?		<ol> <li>Was Decedent of I If Yes, specify Cub</li> <li>1 ☐ Yes 2X No</li> </ol>	an, Mexican, Puert  Specify:	o Rican, etc.)	Black, White,	
12-0036	hours ural",	ed by	3 Widowed 4 Divorced	Year or Dates:	162 De	cedent's Usual Occur		166	B1a b. Kind of Business/li	
<u>.</u>	in 72 in "nat	Completed	15. Decedent's Elementary/Secondary (0-12)	rade completed)  College (1-4or 5+)	(G.	ive kind of work done e.  DO NOT use retire	during most of wor d)	king		-
7	ed with ygiene her tha t, th	Com		<u> </u>	Depu	ıty Marsha				of Justice
yland	t be file antal H ed oth	Be	17. Father's Name (First, Middle, Las Alonzo Lee Winfie					ne (First, Middle, Maid e Christine	,	
	should and Me s mark umatk	2	19a. Informant's Name/Relationship	<u> </u>	19b. M	ailing Address (Street	and Number or Ru	ıral Route Number, Ci	ity or Town, State, Z	ip Code)
, Mai	and 2 ealth a n 27 is		Vonda Oliver/dau	ghter				Fort Eusti		
saitimore,	Pages 1 nent of H int; If iter iry or otf		20a. Method of Disposition  1 ☐ Burial 2 🛣 Cremation 3  4 ☐ Donation 5 ☐ Other (Spec	Hemoval from State	20b. Place of Dis cemetery, c Chesapea	sposition (Name of prematory or other pla ake Cremat	ory 08/		Location - City or Tltsville,	
Dail	permit. Pages 'Department of Important: If ite any Injury or of once.		21. Signature of Funeral Service Lice	11 1111	01251	Soverly I	*Crematic	on Service	P.O. Box	x 784 e, MD 21029
ı			23a. Part 1. Enter the disease, or con shock, or heart failure. List onl	mplications that caused the						Approximate Interval Between Onset and Death
	Physician	i	Immediate Cause (Final disease or condition		2010 2	CAN	CER			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):					
	P +	ner	Sequentially list conditions, if any, leading to immediate outce. Enter Underful y Cause (Disease or injury that initiated events	b Due to (or as a co	onsequence of):					
	ecuted and transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a co	onsequence of).					
8/60,	ficate be executed physician and s the burial-transit	dical E		d						
Þ	ertifica ling ph e as th	Medi	IF FEMALE:	00-16		- :-				
.C. BOX	w requires that the death certifi been signed by the attending should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of p  1  Live birth 2  4  Pregnant at tim 9  Unknown	Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date of deli Month	very Day Year
ecords, P.	requires that the	ğ	Part II. Other significant conditions	contributing to death but no	ot resulting in th	e underlying cause gi	ven in Part I.		co use contribute to	. 1
Heco	The law rec ate has bee page 2 shou	Completed						24a. Was an autopsy performed 1 □ Yes 2 ½	prior to c	topsy findings available completion of cause of
VITAI		Be Co	25. Was case referred to medical				26. Place of Dea	1 □Yes 2 [ặ ath <i>(Check only one)</i>	[No   1∐Yes	2 □ No
o 	Physician; r this certific ral director,		examiner? 1 □ Yes 2 ☒No	2-2-3		Ment 3 1 DOX		lome 5∭ Residenc	. ,	cify)
	ding Physi h. After this c funeral dire	tion:	27. Manner of Death 1     Natural 5	28a. Date of Injury (Month, Day, Ye	ear) 28b. Tim Inju	ry Wo	ıryat rk? ]Yes 2∐No	28d. Describe how i	injury occurred	
UNISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification: To	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine		- At home, farm, Specify)	street, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
_	ospital hours a uneral C		29a. Certifier 1   Check only 2   Medical Ex	Physician: To the best of maminer: On the basis of ex	ny knowledge, d	eath occurred at the	time, date and plac	e, and due to the caus	se(s) and manner as	s stated.
	thin 24	Medical	one) 29b. Signature and title of certifier	and manner stated			se number		. Date signed (Month	
	₹. <u>₹</u> .₹.8	_	Same th	I Cull is	w		39190		igust 11,	
(			30. Name and address of person wh	a completed cause of death	h (Item 23a) (Ty 3 Olanwo	pe, Print) od Ct. Su	ite 111 0		<u> </u>	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 13	22 Paintraria	Signaturo	Soule				
	9			1	6					

DHMH 17 Rev 1/2001

amend #19lease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23art1,23,27,28a-f per me, 8882,08729/08dhb Reg. No. 1 - For A State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** William Marshall Stephen AUGUST 2008 17:40 /Medical 13, 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner WMHS - MEMORIAL CAMPUS CUMBERLAND ALLEGANY if Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M M 2 □ F Maryland Director 215-20-5356 82 July 18, 1926 Usual Residence of Decedent 10c. City. Town or Location f show 10a State 10b. County 10d. Inside City Limits notified at 1 Yes 2 No Director Lonaconing Allegany Maryland 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15908 St. Mary's Terrace S.W. must be 21539 USA Items 23a by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itel any finury or other traumatic event, the Medical Examine 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Verna Smith William Stephen ဥ 19akinformant's Name/Belationship Hype / rintife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15908 St. Mary's Terrace S.W., Lonaconing, Maryland, 21539 Katherine Stephen - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition August 16, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cumberland, Maryland **Cumberland Crematory** 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street Lonaconing, MD 21539 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1ASC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a ry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical signed by the attending I IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) P.0 1 Yes 2 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an certificate has autopsy performed? res 2 No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2) 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this 28a. Date of Injury **FOUND**<sup>th</sup>, Day Year) **08/05/2008** 27. Many er of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury Accident tolural 5 | Pending 1 ☐ Yes 2 No Subject fell **Unknown**<sup>M</sup> death. investigation To the Hospital or Attend within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 15908 St. Mary's Terrace S.W., Lonaconing, MD 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 THomicide Home 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25406 AUGUST 14, Z008 am m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Cumberland MD 21302 Jan 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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2008

08-06099 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 27481 James T. Shillingburg State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 9, 2008 Shillingburg 2018 hrs James Thomas Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Western Maryland Health System - Braddock Campus Cumberland Allegany If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 219-96-8325 Months Davs Hours Min .09/19/1964 Director 43 Country) 1 XM 2 F Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Allegany Rawlings 1 X Yes 2 No MD 28a-f show notified at once. with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 18308 McMullen Highway 21557 Unaited States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status must be White, etc. death v Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married Yes 2 X No white 5 after 4 X Divorced Yes, Give Year Yes 2 X No specify: Widowed "natural", à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 hours Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Flooring it: If item 27 is marked other than other traumatic event, the Medical Floor Mechanic Baltimore, MD 21215-0036 12 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shillingburg Shillingburg James Jenny Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 18308 McMullen Highway, Rawlings Maryland 21557 Jerry Shillingburg/brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 08/14/ crematory or other place) Burial 2 Cremation 3 Removal from State Cumberland Maryland Department o
Important:
injury or oth Cumberland Crematory 2008 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Boal Funeral Home Way 111 Church St, Westernport, Maryland 21562 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a Atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED 23a,27,perME, g882 8/27/08 TT X UNPENDED attending physician or use as the burial Box 68760 IF FEMALE: 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Dav Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown the signed by t be detache 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Completed by Yes 2 No 3 Probably 4 ✔ Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 No No 1 V Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Division of Vital Be Hospital: Other-Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural n 24 hours after death.

e Funeral Director: A letely filled in by the fu Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2 To the 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OCME August 11, 2008 O.C.M.E. 30. Name and address of person who completee cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD.

Registrar

31. Date filed (Month, Day, Year,

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32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygien ) 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle, Last) August 2008 **Physician** 5:08 Рм Bernice Josephine /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Feb. 20, 1 9. Birthplace (State or Foreign 5. Social Security Number 6 Sax 7. Age (In vrs. last birthday) **Funeral** Days 1 ☐ M 2 🛱 F 469-09-8089 Yrs. 96 1912 NE Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or Itema 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Funeral Director MD Gaithersburg Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 301 Russell Avenue #421 20877 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinat once. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: δ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Christian Larson Selma Lundberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1021 Autumn Crest Court, Westerville, OH 43081 Alan Varhus / Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Metropolitan 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State August 7 4 □ Donation 5 □ Other (Specify) Crematory Alexandria, Virginia 22. Name and Address of Facility
DeVol Funeral Home, 10 East Deer Park Drive,
Gaithersburg, MD 20877 21. Signature of Funeral Service Licensee 1 RACIAL STUVE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final disease or condition resulting in death) Adu Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 Yes 2 No 4□Pregnant at time of death 5 Other (specify) P.O. I page 2 should be detached 9 Unknown à Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ OSTROMA 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Jurising Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After thi 28c. Injury at Work? 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 004115 CAITHERSBURG, RULL who completed cause of death (Item 23a) pe, Print)
TSIRSCCTBALL, MA 31. Date filed (Month, Day, Year) 327Registrar's Signature State AUG 1 1 2008

DHMH 17 Rev 1/2001

Registrar

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				e (First, Middle, Las	st)				2. Date of Dea Month	th Day Year	3. Time of Death
	Physicia /Medic		Mary El	lizabeth Y	/anSickle_				August	18, 2008	6:25 A <sup>M</sup>
	Examin		4a. Fecility Name (	If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	ith
			266 Frie	endsville	Rd.		Accider			Garrett	
	Funeral		5. Social Security N		ex 7. Age	(In yrs. last birthday	If Under 1 Year   Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	year) 9. Bir	thplace (State or Foreign ountry)
	Director	ļ	173-18-7	7090	2431	88 Yrs.		}	Aug. 25	, 1919 Mar	yland
	and *	}	Usual Residence o 10a. State	10b, County		10c. City, Town or I	ocation				10d. Inside City Limits
	Aaryii F sho	ō	MD	Garrett		Accident					1 ☐ Yes 21 No
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	death with the Maryland ims 23e or 28e-f show	ᄒ			D.A		21520	1		USA	·
	ns 23	Funeral	11. Marital Status	endsville	12. Was Decedent I	Ever in U.S. 13	Was Decedent of H				
	r iten	듄		ied 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N	lo			Rican, etc.)		ite, etc.
15-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other then "neturel", or Items 23e or 28e-f show other then "neturel", or Items 23e or 28e-f show event. The Madical Exercitive Frankled at	<u>م</u>	3 🙀 Widowed	4 Divorced	1 Tyes 2 10 N If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:		Specify:	White
Ş	2 ho	Completed	/San	15. Decedent's Ec	ducation	16a. Dec	edent's Usual Occup	pation	rin a	16b. Kind of Business	s/Industry
Ž	thin 7	ם	Elementary/Sec		College (1-4or 5	i+)	e kind of work done DO NOT use retired	d)	9		
717	gient er th	5	12			Hom	emaker			Own Ho	ome
2	al Hy al Hy d oth	Be (	17. Father's Name	(First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
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Maryland	2 should be and Mental is marked creumatic every	1		ame/Relationship (						r, City or Town, State,	Zip Code)
	es 1 and 2 should b of Health and Menti if Item 27 is marked ir other treumatic				ickle/Son		6 Garrett				Town Chata
Baltimore,	of H		20a. Method of Dis		Removal from State	cemetery, cr	osition (Name of ematory or other place	ce)	Date 01 ft	20c. Location · City of	
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<u>a</u>	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		21. Signature of F	uneral Service Liger		1				neral Homes	
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			23a. Part1. Enter shock, or hea	the disease, or com an failure. List only	plications that caused one cause on each lin	Ithe death. Do not e ne.	nter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause disease or conditi	on	a. End Stac	re COPD					years
	/Medical Examiner		resulting in death)		Due to (or as	a consequence of):					
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1	P #	la La	Sequentially list of if any, leading to it cause. Enter Und Cause (Disease of	mmediate erlying	Due to (or as	a consequence of):					
	and	Examiner	that initiated event resulting in death)	S (	C. Due to (or as	a consequence of):					
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X Q Q	atten for u	by Physician/M	in the past 12	2 months?	1 ☐ Live birth 4 ☐ Pregnant at		□Ectopic pregnanc; □ Other (specify)	у		Month	Day Year
o.	w requires that the de been signed by the s should be detached	ıys	1 ☐ Yes 2 9 ☐ Unknow		9□ Unknown						
J.	that led by deta	4 4	Part II. Other sign	ificant conditions	ontributing to death b	ut not resulting in the	underlying cause giv	ven in Part I.	23e. Did to	obacco use contribute	to the cause of death?
ecords	uires n sigr		Severe F	VD, HTN,	Hyperlipid	demia, Chr	onic Rena	l Failure	17.73(1	/es 2 □ No 3 □ F	Probably 4 Unknown
<del>ဂ</del> ္ဂ	w req beel shou	lete							24a. Was	an 24b. Were a	autopsy findings available
Ě	The law requires that the rate has been signed by the page 2 should be detache	Completed	CHE, Car	colomyopat	hy, Ischer	nıa				rmed? death?	completion of cause of
Ital		ပိ	25. Was case refe	rred to medical			- <del> </del>	26. Place of Dea		-A	s 2 No
>	sicia	o Be	examiner?		Hospital:	ent 2 ER/Outpati	ent all DOA Ott			dence 6 Other (Sp	ecify)
<u></u>	Phy r this aral d	-	27. Manner of Dea	-	28a. Date of Inju		of 28c. Injur			now injury occurred	33.177
DIVISION	ading th. : Afte	텵	1 X Natural 2 Accident	5 Pending investigation		y Ye <i>ar)</i> Injury		rk? ]Yes 2 □No			
<u> </u>	Atter r dea ector by the	ifice	3 🗆 Suicide	6 Could not b determined	200. Flace of Inj	ury - At home, farm,	street, factory, office		28f. Location (5 City or Tox	Street and Number or F	Rural Route Number,
É	s afte	Certification:	4 🗍 Homicide		building, et	c. (Specity)			City of Top	wi, State)	
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier	1☑ Certifying Ph	nysicien: To the best	of my knowledge, de	ath occurred at the ti	me, date and place	and due to the	cause(s) and manner a	as stated.
	he Hi in 24 he Fi pletel	Medical	(Check only one)	Z Medicel Exel	and manner st	ated.				date and place, and du	
	To t To t com	Σ	29b. Signature and	thile of certifie	do- 1	6	29c. Licens	se number		29d. Date signed (Mor	
			for	The	1/K-fir	9	HOC	64705		0/15/2	008
	. 6		30. Name and add	lress of person who	completed cause of d	leath (Item 23a) (Typ				,	
		,			orter, 311	N. Fourth	St., Oak	cland, MD	21550		
	Sta		31. Date filed (Mo.	nth, Day, Year)	0 2008 ▶	ar's Signature	Showsh	7			
	Registr	7 L		B B B B B B	3	N. DEFER	Department of				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 8 / 1 4 / 2008 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician William Frederick Arrington, I 11:03 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA GOOD SAHABITAU 0 13 E 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 11-20-1945 Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 XM 2 □ F 62 Director N.C. 219-52-4812 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, it is Medical Extendent must be notified at 1√Yes 2□No Directo N/A Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with 4903 Belair Road 21206 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 72 hours after 1 Never Married Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes. Give Specify: þ Specify: Black 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel 12th grade Welder Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jake Arrington Viola Powell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages, 1 and 2 st Department of Health and Important: If Item 27 is n 1721 E. 33rd Street Baltimore, MD 21218 Thomas Arrington-Brother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or 8-23-2008 Randallstown, MD King Memorial Pk 22. Name and Address of Facility 21. Signature of Funeral Service Licenses March East F/H any contrae 1101 E. North Avenue Balto, MD21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CARDIAC ARREST disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner EU ER E Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine been signed by the attending physician and should be detached for use as the burial-transit death certificate be executed TASI LON Due to (or as a consequence of) Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) I∐Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PULKOUARY OBSTRUCTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate 2 ÉNo funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Watural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death.

Director: A in by the f 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar

Devination, Milliam

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 2

7

2008

29c. License number

RAVEN

29d. Date signed (Month, Day, Year) 8/14/2008

and manner stated.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year **Physician** 1255AM AUGUST SIDNEY ALLEN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SEASONS HOSPICE RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □XM 2 □ F 219-40-8609 64 11-27-1943 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show Department of Health and Mental Hygiene important: If them 27 is marked other than "natural", or items 23a or 28a-f show important: If them 27 is marked other than "natural", or items 25a or 28a-f show important: If the Modical Examination and the notified at some. N/A 1 XYes 2 No MD. BALTIMORE Director the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 1650 WOODBOURNE AVE. APT 218 USA 21239 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -12--0-LABORER CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SIDNEY D. ALLEN SR. ANNIE MAE BOOKER ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEAN E. WILSON(SISTER) 6714 PARSONS AVE. BALTIMORE, MARYLAND 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ∕ Cremation 3 Removal from State KING MEMORIAL PARK 8-23-2008 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service D. HIBNER2. Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediae Cause (Final disea For condition resulting in death) End Stage Renai Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to (or as a surrequence of) if any, leaving to inimedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed burial-transit and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as the t law requires that the death certificate IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month in the past 12 months? Day Year 5 Other (specify). 1 ☐ Yes 2 ☐ No P.O. the detached 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) SEASAUS Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 M No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Coertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lone 25 MAIN eporah 57 NEISTENSTUNN 32. Rigistrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 2008 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 2:15 PMM Gonzalez Buell August 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2132 Coralthorn Road Middle River Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/26/1920 Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Months Days 1 □ M 2 🛣 F 216-28-1958 88 Director Puerto Rico Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shoute Medical Examiner must be notified at 1 ☐ Yes 2 X No Middle River Director Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21220 2132 Coralthorn Road U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1X Yes 2 □ No Specify: Puerto Rican \$ Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nt: If item 27 Is marked other than " Elementary/Secondary (0-12) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rafael Gonzalez Ortiz Ana Carrasquillo Rodriguez traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 s
Department of Health ar
Important: If item 27 is,
any Injury or other trau 18 North Hampton Road, Timonium, Maryland 21093 Yvonne Zuckerman (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/29/2008 4 Donation 5 Dother (Specify) Timonium, Maryland Dulaney Valley Mem. 22. Name and Address of Facility Bruzdziński Funerla Home, P.A 21. Signature of Funeral de vice Licenson 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. e of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown s been signed by a should be detach þ Completed this certificate has page 2 Be Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Par	1   23e. Did tobacco use contribute to the cause of death?  1   Yes 2 12 No 3   Probably 4   Unknown
		24a. Was an autopsy performed? 1 □ Yes 2 □ No 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical examiner?	26. Pla	ce of Death (Check only one)
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐	Nursing Home 5- Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day, Year)  28b. Time of Unjury at Work?  1 □ Yes 2	28d. Describe how injury occurred □No
3 ☐ Suicide 6 ☐ Could not be determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying P	nysician: To the best of my knowledge, death occurred at the time, date miner: On the basis of examination and/or investigation, in my opinion, o	and place, and due to the cause(s) and manner as stated. leath occurred at the time, date and place, and due to the cause(s)

10

Medical

29b. Signature a

29d. Date signed (Month, Day, Year)

STERSTOWN Rd GEZZI-PIRBULLE 21208

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 8:30AM James Jerome Blazek, Sr. 2008 Tu que /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORES ST AGINES HOST FTAT If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours XXM 2□F 214-26-2560 78 Sep. 3, Director 1929 Maryland Usual Residence of Decedent 1 and 2 should be fit, d within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County r 28a-f sh notified 1 ☐ Yes XX No MD Baltimore Reisterstown Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or Items 23a or Examiner must be r 105 Sunnydale Way 21136 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXXYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XX No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Korea Specify: White XXWidowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chemical Engineer Chemica1 7 is marked other traumatic even , tl 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph F. Blazek Barbara P. Gross 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) If item 27 or other tra Barbara Regan / Daughter 4098 Roxmill Court, Glenwood, MD 21738 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake View Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 08/29/08 Sykesville, MD 4 Donation 5 DOther (Specify) Memorial Park 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Function Service Licenses 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
UNICULWY Immediate Cause (Final coron concept METUSTATEC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to him deltacause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 TYPS 2 TNO 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ျှ 1 TYes 2 JUNE 2 ER/Outpatient 3 DOA this 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the date of the date of the date of the date of the cause (s) and manner as stated. 29a, Certifier Medical

or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: Division

Registrar

DHMH 17 Rev 1/2001

KOPPL &UCST-31. Date filed (Month, Day, Year)

30. Name and address of person

29b. Signature and title of certifier

(Check only one)



and manner stated.

29c. License number

1006070S

BUTLTUNISE

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Cer	tificate of Death	) F	Reg. No. 2008	3 27488
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month	th Day Year	3. Time of Death
	/Medi Examir	cal	Wilbur G. Baumann  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location	August of Death	24, 2008 4c. County of Dea	6:45 a <sup>M</sup>
e'	Examin	iei	Glen Burnie Health And Reh	ab.	Glen Burr	ie	Anne Ar	
	Funeral Director		217-01-7582 <sup>№</sup> 2□F 92	yrs. last birthday) Yrs.	If Under 1 Year If Under Months Days Hours	r 24 Hrs. 8. Date of Birti Min. (Month, Day 01/14/	(1916) 9. Bir 1916	thplace (State or Foreign buntry)  MD
	yland now			. City, Town or Loc				10d. Inside City Limits
	e Mar Ba-fst	Director	MD		Baltimore			12∑Yes 2 □ No
	th with th 23a or 2	ral Dire	10e. Street and Number 621 East Fort Avenue		10f. Zip Code 21230		10g. Citizen of What Co USA	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examirer must be reculted at once.	by Funeral	11. Marital Status  12. Was Decedent Ever i Armed Forces?  1 ☐ X Se 2 ☐ No If Yes, Give Year or Dates: 194		Vas Decedent of Hispanic Of Yes, specify Cuban, Mexica □ Yes 2 No Specify		14. Race - Ame Black, Whit Specify: Wh	e, etc.
Baltimore, Maryland 21215-0036	rithin 72 ho ne. han "natur e Medicel	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give F	lent's Usual Occupation kind of work done during mo OO NOT use retired) USICIAN	st of working	16b. Kind of Business Religior	
d 2	filed w Hygie other ti ent, in	e Co	11 17. Father's Name (First, Middle, Last)	140		ner's Name (First, Middle,		1
/Jan	uld be Mental rked o	To Be	Charles A. Bauman			elia Yost	,	
, Mar	and 2 sho salth and 1 1 27 is ma er trauma		19a. Informant's Name/Relationship (Type. Print) Luann T. Awalt / Niece	19b. Mailing 626.	g Address (Street and Number 1 Pinyon Pine	ber or Rural Route Number Court, Elde	r, City or Town, State, Prsburg, MI	Zip Code) D 21 <b>7</b> 84
more	Pages 1 ament of He Int: If item Iry or oth			Db. Place of Dispos cemetery, crem eadowside	natary or other place)	Date 08/27/2008	20c. Location - City or Elkridge	
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee Victor P.	Doda 22	Name and Address of Faci Charles L. St 1501 East For	evens Funera	al Home Inc	D 21230
F	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the cand shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a condition or shock)	death. Do not ente				Approximate Interval Between Onset and Death
	ficate be executed  physician and sthe burial-transit	Examiner	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a condition)					,
68760,	cate be ohysicia the bu	Medical	d					
O. Box 6	sath certi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopkns? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 🗌	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
κ, σ.	w requires that the designed by the should be detached	by Ph	Part II. Other significant conditions contributing to death but not	resulting in the un	derlying cause given in Part	I. 23e. Did to	bacco use contribute to	the cause of death?
ord	require een sig rould b	ted t				1 🗆 Yo	es 2 <b>10 N</b> o 3□P	robably 4 🗋 Unknown
		Completed				24a. Was a autops perfor 1	sy prior to	utopsy findings available completion of cause of
Vital	ysıcla is certi directo	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2	2 ☐ ER/Outpatient	Othor	e of Death (Check only on ursing Home 5  Resid		acity)
0 	iding Physician: th. After this certifications funeral director, p	On: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day, Yea.	28b. Time of	28c. Injury at Work?		ow injury occurred	(Sing)
Division of	7 6 5 9	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Sp	at home, farm, stre ec <i>ify)</i>	M 1 □ Yes 2 □ eet, factory, office		treet and Number or R n, State)	ural Route Number,
_	Io the Hospital or Affe within 24 hours after de To the Funeral Directo completely filled in by th	edical Co	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my and manner stated.	knowledge, death nination and/or inv	occurred at the time, date a restigation, in my opinion, de	and place, and due to the cath occurred at the time, c	cause(s) and manner a late and place, and due	s stated. e to the cause(s)
	Io the within To the compl	Me	29b. Signature and title of certifier		29c. License number 0 2 0 0 4	4	29d. Date signed (Moni	th, Day, Year)
	8		30. Name and address of person who completed cause of death ( E//Leff Gn bally MD)	Item 23a) (Type, P		Drive 6	len Burnie	ud 21061
	Sta	te	31. Date filed (Month, Day, Year) 32, Registrar's Si	gnature	asti)			1

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ye ar ROBERT JOHN CHARLTON August 7:00 AM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner tealth Care S Your 90 If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) Social Security Number Date of Birth (Month, Day, **Funeral** 6. Sex Age (In yrs, last birthday) Year) Months Days Hours 1 M 2 □ F 219-30-1040 Director SEPTEMBERH 1934 MARYLAND Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show 1 ☐ Yes 2 No Completed by Funeral Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 31333 PENINSULA EXP APT 404 "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give June 1956 Year or Dates: 3016 1958 1 ☐ Yes 2 ☑ No 3 ₩Widowed 4 □ Divorced Specify: WHITE ..... s should be filed within 72 ho. of Health and Mental Hygiene. 'them 27 Is marked other there'... 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION MANAGER, BUILDING SUPPLY 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBFRET CHARLITON LAURA MAGALSKI ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FORESTHILL, MD 21050 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other to once. DENISEH. MIGHER / NIECE 2930 SMITHSON DR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State JUNIOURS MARYUND ARDENT CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) DODG TETZVIJUA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ARBENT CREMENTED DR STEN HONORR MD 21076 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): certificate be executed signed by the attending physician and if be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Year Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1  $\square$  Inpatient 2  $\square$  ER/Outpatient 3  $\square$  DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending 1 Natural 2 Accident 5 Pending after death. 1 □Yes 2 □No investigation completely filled in by the 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 24 hours a 29a. Certifier Tx certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. VA Maybal Health Morros S. Milke WD 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Name Known To Pinysician: Charlton, Ribert J

Amend 10b, 10c, 10e, 10f, 14, 20a-c, 22, per FH G882 8/27/08 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** 12:05 AM Herman Dawson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAMARITAN HOSPITAL ALT INDRE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 212-56-2536 56 Dec 19, 1951 Director Usual Residence of Decedent show d at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Baltimore MD **Baltimore Essex** 10e. Street and Number 308 Stemmers Run Rd. 10g. Citizen of What Country? 10f. Zip Code 21224 08/12/08 USA 5009 Frankford Avenue 21206 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. White DAWSDN , HERMAN L. PT# 1019583374 MR# 212562536 1 Never Married 2 Married Specify: black 1 ☐ Yes 2 📉 No Specify: 2 3 Widowed 4 Divorced Pt Dir Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12/19/1951 56 M IMC BHARAJ, NARENDER TEAM RED-PARKER FIRM Elementary/Secondary (0-12) College (1-4or 5+) unk truck driver transportation unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kenneth Jacob Dawson Bernice Bepp Louk 2 12/19/1951 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 Stemmers Run Road Essex, MD 21221 Kathleen Dawson/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 X Corner (Specify) 1n State Chesapeake Crematory 8/29/2008 BEltsville, MD Departmi Importar any injur once. 21. Sign ture the state Sienses Diffector St. Nice and does the CAFA Stephen Lohrman, P. A. 1-27 Baltimore, MD 21201 21286 8717 Green Pastures Dr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician NEU MONIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CHERICA Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hospital or Attending Physician: The Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other:  $4 \square \text{Nursing Home} \quad 5 \square \text{ Residence} \quad 6 \square \text{Other (Specify)}$ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this jo 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Division 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatl Funeral Director: filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier REJ-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAKIM BLUD 31. Date filed (Month, Day, Year) 12. Registrar's Signature State 2008 AUG 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1,23e 27, perMD, g882 8/27/08 TT State of Maryland / Department of Health and Mental Hygiene Reg. No 2008 27491 Certificate of Death 1. Decedent's Name (First, Middle, Last) Marian L Dixon 2. Date of Death 3. Time of Death Physician Day Marian L. Dixon 9:25 M Aubust 2008 /Medical 18 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE N/A SAINT 16NES HOSPITAL If Under 1 Year | If Under 24 Hrs. | Months Days Hours | Min. 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 XF 217-68-3124 Director 8/18/08 MD Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at Baltimore N/A MD Director 1 ☑ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21201 819 W. Saratoga St.-Apt. Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☐ 💢 to Specify: þ 3 Widowed 4 Divorced 'natural', American Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Coast Guard Department of Health and Mental Hygiene, Important: If Item 27 is marked other thar any injury or other traumatic event, the M once. Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Dixon Ernestine White 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernestine Dixon/Mother 819 W. Saratogo St.-#4, Balt., Md21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 8/23/08 Balt. MD 4 Donation 5 Other (Specify) Zion Cem 22. Name and Address of Facility Hari P. Close F. Svs, PA 21. Signature of Funeral Service License 5126 Belair Rd, Balt., MD 21206-5105 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** KESPINATORY TAILUNE DAY S /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be execute burial-tra Due to (or as a consequence of): Division Vital Records, P.O. Box 68760, physician Physician/Medical the. attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tes 2 No 3 Probably funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate | performed' 2 1 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier P23495 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 EMION IVE BALTIMORE MI) 21229 SYCHANGCO 31. Date filed (Month, Day, Year) egistrar's Signature State 7 2008 AUG 2 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2008 Month AUG Physician 21, 1335 Barbara Liston Dick /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Tokoma Park Montgomery Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) APR 7, 1931 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1 □ M 2 🛣 F Scotland Director 99 9-99-9999 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shoi traumatic event, the Modical Examirer must be notified at Woodstock 1 ☐ Yes 2XXVo 0xford Director Ontario 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number N456H5 Canada 194 Light Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene. is marked other than "natural", or iter 1 ∐Yes 2X If Yes, Give Year or Dates: 1 Never Married Married 2X No White altimore, Maryland 21215-0036 1 □ Yes 2XXNo Specify. Specify ≥ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plastics Broker Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Woodburn ၉ Catherine Galt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 194 Light St., Woodstock Ontario, Canada N456H5 Health a permit. Pages 1 an Department of Heal Important: If Item 27 any Injury or other tr. once. Archibald Dick/Husband 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 🏋 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date AUG 25,2008 Woodstock, Ont, Canada Smith-LeRoy F/H 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility M00382 Rapp Funeral and Cremation Svcs 939 Gist Ave., Silver Spring, MD tiple Holuncum 20910 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Research Candidate) **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): QRSTITAL Examiner PHYSE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed and attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) o cate has been signed by the page 2 should be detached 9 ∏ Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>م</u> 1 Yes 2 🗌 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ₩ No 1 M Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 1 Natural Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. it of certi 29d. Date signed (Month, Day, Year) 29b. Signature as of person who completed cause of death (Hem 23a) (Type, Print) Name and address 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

AUG 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month & Year **Physician** 5: SIAM HENRY SYKES DAVIS 2 200 8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore N/AIf Under 1 Year | If Under 24 Hrs. 8. Date of Birth MAR. 30, 1946 Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 15 M 2 □ F Min. Months Days Hours 62 216 42 8364 Director MD. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits worle other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director MD N/A BALTIMORE 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 4557 HAZELWOOD AVE. 21206 Items 23a USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married Married ☐Yes 2 No 10. 1 □ Yes 2 No BLACK Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) milk delivery (truck 8th Cloverland Milk Co permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 le marked othe any lighty or other traumatic event, 20cg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Calvin Davis Helen Banks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Davis (wife) 4557 HAZELWOOD AVE. BALTO, MD. 21206 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State M☐Burial 2 ☐ Cremation 3 ☐ Removal from State AUG. 30,2008 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) OAK LAWN CEM. 21. Signature of Funeral Service Licensee CALVIN B. SCRUGGS FUNERAL HOME 1412 E PRESTON ST. 21213 BALTO, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Septic Schock /Medical Due to (or as a consequence of) Examiner nlumo ni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit lung disease nterstitia Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No certificate has autopsy performed 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No iours after death neral Director: A filled in by the fu investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 24 hours af To the Funeral D completely filled in

Registrar

Medicai

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Martingay 2 refa) 2008

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMIR KAZORY 56-1 LOCK RAVEN BIVOL BOTTON , MD 212

31. Date filed (Marth Gay) 700) 2000 Sec. Adjustrar's Signature

🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Kes-000

29d. Date signed (Month, Day, Year)

08-23-2008

State

Registrar

6

3altimore, Maryland 21215-0036

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

			1 - For State amend #10c	State of M Per FH G882	aryland / [ 2 <b>/8/27/0</b> 8	epartmen Certificat	t of Health e of Deatl	and Mer	ntal Hyg	jiene <sub>reg. No.</sub> 200 (	3 27495
	Physic	ian	1. Decedent's Name (First, Middle,	Last)					Date of Dea Month	th Day Year	3. Time of Death
	/Medi		ROHALD	ZUAUS				A	OGUST	23 200	8 4:12 × M
	Examir Funeral	ner		JGTON MED	OICAL E	STER	GLEN  1 Year   If Under	Bull	Date of Birth	4c. County of Dea	th RUNDE L
	Director		216-17-3741  Usual Residence of Decedent	<b>№</b> M 2 🗆 F		Yrs. Months	Days Hours	Min. 7	Date of Birth (Month, Day /12/8	37 MD	ountry)
	death with the Maryland rms 23a or 28a-f show r must be rodified at	ctor	10a. State 10b. County N/A		10c. City, Town	or Location  Loude	n Ave	Balt	imore		10d. Inside City Limits 1 □Yes ※□ No
	with the 3a or 28	Il Dire	10e. Street and Number 527 N. Loude	n Ave		10f. Zip	Code 21229		1	0g. Citizen of What Co	ountry?
9036	urs after ai", or ite Examine	d by Funeral Director	11. Marital Status  1 XNever Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? d 1 □ Yes 2 ☑ If Yes, Give Year or Dates:			ent of Hispanic C ify Cuban, Mexic Carried Specif		Yes or No- an, etc.)	14. Race · Ame Black, Whit Afri Specify Ame	e, etc.
i RowaLD Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, Ite Mudical once.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 10	Education grade completed) College (1-4or s		Decedent's Usua (Give kind of wor life. DO NOT us Labore	k done during mo e retired)	ost of working		16b. Kind of Business Construct	/Industry
OJALD yland 21	uld be file Aental Hy rked oth tic event	To Be (	17. Father's Name (First, Middle, La Ronald D. Ev					her's Name <i>(Fi</i> ohne M		Maiden Surname) odin	
	od 2 shou alth and M 27 is ma r trauma		19a. Informant's Name/Relationship Tiffany T. E							City or Town, State,	Zip Code)
EVANS Baltimore,	Pages 1 arment of Hezant: If item		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐ Removal from State	20b. Place of	Disposition (Namy, crematory or of eW Crei	e of	Date		20c. Location - City or Baltimore	Town, State , MD
El Balt	permit. Departimports any inje		21. Signature of Funeral Service Lie	center		22. Name and 5126	Address of Faci Belair	Mari Rd,Ba	P. Cl lt.,M	ose F. S D 21206-	vs,PA 5105
d	Physician /Medical Examiner	Jr.	23a. Part 1. Enter the disease, or conshook, or heart failure. List or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions	a. SEP1  Due to (or as	ne. SiC SHOC a consequence o	SK 1): H BACTE			=		Approximate Interval Between Onset and Death S DAYS
	ificate be executed g physician and is the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence o						
.O. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pr 5 ☐ Other (spe				23d. Date of de Month	livery Day Year
ords, P.	w requires that the de s been signed by the a should be detached to	δ Ω	Part II. Other significant condition				use given in Part	: I.		pacco use contribute to	o the cause of death?
Division of Vital Records,	sician: The law r certificate has be rector, page 2 sh	Completed							24a. Was ai autops perforn 1 □ Yes 2	y prior to	utopsy findings available completion of cause of
Vit	siciar certif	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	Hospital:			Othori	ce of Death (CI			
n of	ding Phys h. After this funeral dir	ion: To	27. Manner of Death 1 K Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ent 2 ER/Out iry 28b. Ti y, Year) In	me of 28	Sc. Injury at Work?	28d.		ence 6 Other (Spe ow injury occurred	ecify)
Divisio	al or Attendii after death. I Director: A d in by the fu	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 200 Place of Inju	ury - At home, farr c. (Specify)	m, street, factory,	1 ☐ Yes 2 ☐ office		Location (St. City or Town	reet and Number or R n, State)	ural Route Number,
	To the Hospital or y within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier (Check only one)  1  CertifyIng 2  Medical Ex	Physician: To the best aminer: On the basis o and manner sta	f examination and	death occurred a l/or investigation,	at the time, date a in my opinion, de	and place, and eath occurred a	due to the catter the time, do	ause(s) and manner a ate and place, and due	s stated. e to the cause(s)
	To th Within To th COMP.	Me	29b. Signature and title of certifier			29c.	License number			9d. Date signed (Mont	-
			Cuilonno Ira	Cimpres		Do	115500	4	P	1000st 33	800508
	7		30. Name and address of person wh	o completed cause of d	ECO 301		C DAIVE	usso,	BURN	iE, MD 20	/6/
	Sta Registra		31. Date filed (Month, Day, Year)	1008 33 Registra	ar's Signature	best					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 10:288 M 22,2008 horissI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ser If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 2 F Months Days Hours Min. Year) 246-36-9584 6,1926 North Canlina Director )une Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Madical Examinat must be natified at ma 1 Yos 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 10 Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industr Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Pages 1 and 2 should be f nent of Health and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) daustites permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation / 5 ☐ Other (Specify) 21. Signature of uneral S 22. Name and Address of Facility Fred HILTON Balto, md. 21229 23a. Part. F. 1. th disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Couse (Final disease or condition resulting in death) **Physician** Mycardial infaret /Medical Du to (or as a consequence of): Examiner somely whilely Sequentially list conditions, if any 1-2 in the late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of): attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed Due to for as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 12 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 VNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 753

Registrar
DHMH 17 Rev 1/2001

State

1600 W. MOUNT

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DARSHAN

31. Date filed (Month, Day, AUG 2 7

5

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

			For State Registrar		Otate of IV	iai yiai i	•	rtificate of	Death		leg. No.	18 21491
	Physicia	an	1. Decedent's Name (F	First, Middle, Las	st)					2. Date of Dea Month	- 3	3. Time of Death
	/Medic	al	Willia		Gunn			4h City Town o	r Location of Death		4c. County of	2008 2116 M
	Examin	er	4a. Facility Name (If no	1 1	e street and numbe Adventis			4b. City, Town, o	Takoma F		Montg	
	Funeral		5. Social Security Num	hingdon ber 6. S			ast birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.		_	Birthplace (State or Foreign Country)
	Director		578-60-49	78	<b>2</b> M 2□ F	63	Yrs.	Months Days	Hours Min.	01/2	1/1945	MD
	and		Usual Residence of De 10a. State 10	ecedent 0b. County		10c. City	y, Town or Lo	cation				10d. Inside City Limits
	Maryl -f sho	ţō	MD	Montgo	merv	Та	koma 1	Park				1 Yes 2 No
	r 28a	Director	10e. Street and Number					10f. Zip Code			10g. Citizen of Wh	at Country?
	th with		701 Ethan	Allen	Ave. #104			20912			United	
15-0036	thin 72 hours after death with the Maryland e. an "natural", or Items 23a or 28a-f show Midcal Even in er ust be notified at	by Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>3 ☐ Widowed 4 [</li></ul>	_	12. Was Deceder Armed Forces 1 □ Yes 2 No If Yes, Give Year or Dates	No		Was Decedent of Hif Yes, specify Cub. 1 □Yes 2 ☑ No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Ye's or No- o Rican, etc.)	14. Race Black,	- American Indian, White, etc. Caucasian
ָה ק	72 hou	sted	(Specify	5. Decedent's Ed	ducation		16a. Dece	dent's Usual Occup	pation during most of work	kina I	16b. Kind of Busi	
7	filed within 72 Hygiene. other than "natent, I'm Midic	Completed	Elementary/Seconda	, , ,	College (1-4o	r 5+)	,		during most of work d)	9	Automot	tive Parts
7.	al Hygier other th	S.	12 17. Father's Name (Fir	rst Middle Last	)		Sale	es Clerk	18 Mother's Nam	ne (First. Middle.	Maiden Surname	
Maryland	ed of of	m	Louis Wil								th Erbach	
Ĭ	s 1 and 2 should be f Health and Menta Item 27 is marked other traumatic ev	욘	19a. Informant's Name				19b. Maili	ng Address (Street	and Number or Ru	ral Route Numbe	er, City or Town, S	tate, Zip Code)
	and 2 salth a 27 is		Deborah G	unn/Daug	hter		193	2 Roseman	ry Hills	Dr. Silv	er Sprin	ng, MD 20910-
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra	1	20a. Method of Dispose 1 ☐ Burial 2 ☑ 0 4 ☐ Donation 5	Cremation 3	Removal from Stat	e		osition (Name of matory or other plan ske Crem		Aug 25 2008		ity or Town, State
Balt	permit. Departs Imports any Inji once.		21. Signature of Fune	rai Service Licer	Brue 1	Mols	33 2	2. Name and Addre Rapp Fune 933 Gist	ral & Crem	mation Se ver Sprin	rvices g, Maryla	and 20910-
**	Physician		Immediate Cause (Fir	failure. List only	one cause on each	line.	4.5	ter the mode of dyi		or respiratory ar		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)			as a consequ		and over	war yare	021		
	Examiner		Sequentially list condi	tions.	D. 7 7 7		מטוז					
	sit / sed	ine	Sequentially list condi- cause. Enter Underlyi Cause (Disease or inji- that initiated events	ing 4	Due to for a	as a consequ	uence of):					
•	al-tran	Examiner	that initiated events resulting in death) Las	st	c Due to (or a	as a consequ	uence of):		· · · ·		· · · · · · · · · · · · · · · · · · ·	
68760,	ficate be executed g physician and s the burial-transit				d							
	rtificat ng ph) as th	Medi	IE EELINE									
O. Box	death ce e attendii d for use	Physician/Medical	IF FEMALE:  23b. Was decedent print the past 12 mo  1 □ Yes 2 □ N  9 □ Unknown	onths?	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	n 2 ☐ Feta t at time of c	death 3	☐ Ectopic pregnand			23d. Date Mon	of delivery th Day Year
 J.	s that ned b	by Pr	Part II. Other significa	ant conditions	contributing to death	but not res	ulting in the u	ınderlying cause gi	ven in Part I.	23e. Did to	obacco use contril	oute to the cause of death?
g	equires							-		1 🗆 Y	res 2□No 3	3 ☐ Probably 4 ☐ tonknown
I Records,	The lav ate has page 2	Completed		-						24a. Was autop perfo 1 □Yes	rmed? pr	ere autopsy findings available for to completion of cause of eath?  Yes 2 □ No
Ita	Physician: r this certificanal director, p	Be (	25. Was case referred examiner?	d to medical				l ou		ath (Check only o	ne)	
5	Physic this c	ဥ	1 Yes 2 Noorth	5	Hospital: 1 ☐ Inpa		ER/Outpatie	nt 3 DOA		1	dence 6 Othe	
u Q	ling After fune	tion		5 ☐ Pending investigatio	(Month, i	Day, Year)	Injury	Wo	rk? ]Yes 2 □ No	260. Describe i	now injury occurre	u
Division of Vital	deat deat ctor: y the	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined		Injury - At ho etc. <i>(Specit</i>	ome, farm, st	reet, factory, office		28f. Location (S City or Tov		r or Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	Medical C			and manner	s of examina stated.	ation and/or i	nvestigation, in my	opinion, death occu	urred at the time,	date and place, a	nd due to the cause(s)
	To the within To the Somple	Me	29b. Signature and titl	le of certifier			-	29c. Licen	se number		29d. Date signed	(Month, Day, Year)
B	11		1/4/2	1/2	~			T	200676	58	08/2	2/08
7	15		30. Name and addres	10	completed cause of	f death (Iter	n 23a) (Type	Print)	venue To	Kom- Pa	erk MD	20817
ı	Sta Registr		31. Date filed (Month,	Day, Year)	32. Regi	strar's Signa	iture	berte	se number			

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008

			For State Registrar	,	C	ertificate of	Death			Reg. N	201	JB	214	98
	Physicia	an	1. Decedent's Name (First, Middle, Last Carroll Milt						Date of De Month	D	ay Y	e ar	3. Time of De	eath
	/Medic	al	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location /		ugust		5 200 c. County of		3:45a	IVI
	Examin	er	Gilchrist Hospice			Towson	Location	or Death			altimo			
	Funeral		5. Social Security Number 6. Se	x 7. Age (In	yrs. last birthda	y) If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Min.	Date of Bir (Month, Da	rth ay, Yea	r) §	Birthp	place (State or F	oreign
	Director		218-16-1804	JM 2□F 83	Yrs.				u1y 9		925		MD	
	land ow		10a. State 10b. County		. City, Town or							1	0d. Inside City L	Limits
	Mary a-f sh	ctor	MD Carroll		Sykesvi	.11e							†X⊡Yes 2∣	□No
	or 28	Direc	10e. Street and Number			10f. Zip Code					itizen of Wh	at Cour	ntry?	
	s 23a	eral	7426 Village Roa		- 11.0	21784	lianania Ovi	ining (Conside	. Vo o or blo	US.	A 14. Race -	Amoria	an Indian	
320	2 should be filed within 72 hours after death with the Maryland and Manthal Hygiene. I and Memtal Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever i Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Ye ar or Dates:	WWII	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ XNo	an, Mexicar  Specify:	n, Puerto Ric	an, etc.)	ļ		White,	etc.	
215-0036	'2 hou natura ical E		15. Decedent's Edu	cation	16a. Dec	cedent's Usual Occup ve kind of work done	ation	et of working		16b.	Kind of Busi	ness/In	dustry	
7	ithin 7 ne. nan "r	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	`life	. DO NOT use retire	d)	st of working		We	stern	Ele	ctric	
7	iled w Hygie ther ti	S	12   17. Father's Name (First, Middle, Last)		11	achinest	18. Mothe	er's Name (F	irst. Middle	. Maide	n Surname)			
yiand	ld be i ental ked o ic eve	To Be	John Joseph Gro	oncki				Eva Ro						
Mary	shou and N s mar	۲	19a. Informant's Name/Relationship (Ti	pe. Print)		iling Address (Street							Code)	
e, ≅	and 2 lealth m 27 i		John Groncki (son)			5 Windmer							01.1	
20	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F	nemoval from State		position (Name of rematory or other plan		Date			Location - C			
Бащтог	nit. Pa artme ortant injury		4 □ Donation 15 □ Other (Specify,  21. Signature of Funeral Service Licens			ty Cremat				2.00	esvill	.е,	עויי	
n	Depa Impo any i		Duan ( H	1 1	0769 P	ÄIGHT FUN O Box 195	ERAL I Syke	HOME & esvill	e, MD	21	P.A. 784			
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o										Approximate Interval Between	en
F	Physician		Immediate Cause (Final disease or condition	STROKE									Onset and Dea	atri
£	/Medical Examiner		resulting in death)	Due to (or as a cor	sequence of):								MAVS	
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cor	sequence of):								1000	
	cuted nd ransit	Examiner	triat irritated everits	c										
5	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a cor	sequence of):									
09/90	rtificate ng physi as the t	Medical	<u> </u>	d										
XOD	h certi anding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pro		Totonio nyognon					23d. Date	of deliv	ery	
<u>п</u>	he deat the att	Physician/	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown		3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	-y				Mont	h	Day Yea	ar
τ.	that the the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second sec		Part II. Other significant conditions co	ntributing to death but not				I. ,	23e. Did	tobacco	use contrib	ute to t	he cause of dea	th?
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် မ	law re as be 2 sho	plet					<i>O</i> .		24a. Was	DSV	24b. We	ere auto	opsy findings ava	ailable se of
	: The cate h page	Con							perfo 1 □ Yes	ormed? 2 <b>XI</b>	No 1	ath?	2 🗆 No	
VII	sician certifi rector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	• C = 0 • • •	Ott	or:	e of Death (C			A Effort		14 0100	
5	y Phy: er this eral di	i. To	27. Manner of Death	1 ☐ Inpatient  28a. Date of Injury	28b. Time	of 28c. Inju	ry at	ursing Home 280			occurred		to MOSPIC	<i>P</i>
VISION OF	ending ath. rr: Aft ne fun	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Yea	ar) Injur		Yes 2	]No						
	l or Atte after de Directo J in by ti	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, pecify)	street, factory, office		28f.	Location ( City or To			or Run	al Route Numbe	er,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours atter death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C		sician: To the best of my iner: On the basis of exa and manner stated.										
	To the within To the comply	Me	29b. Signature and title of certifier			29c. Licens				29d. [	Date signed	(Month,	Day, Year)	
			) June	NO		D	58	303		A	16057	25	2008	
	2		30. Name and address of person who c	ompleted cause of death	(Item 23a) (Typ	e, Print)	he c	5 ( 7)	WSdi	N	M10 2	128	2007	
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's S	4 101	9	- 0 -	1 10	/				/	

DHMH 17 Rev 1/2001

Amend 19a, perrh g082 8/28/08 11 Rlack Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2008 Year Month Aug. **Physician** 26, 7:19pm George Robert Gill /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown Baltimore Chapel Hill Nursing Home 8. Date of Birth A (Month, Bay, Year) 15 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**X** M 2□ F Months Days Hours Min. 93 219-03-7500 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Baltimore Reisterstown Md. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 4020 Osborne Rd. 21136 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl J. Leski George Washington Gill ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Viola Mae Nelaignoff De. Print) 4020 Osborne Rd., Reisterstown, Md. 21136 <del>Mae Neigholl</del> - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or Aug. 30,2008 Reisterstown, Md. Pleasant Grove Cem. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility

Eckhardt Funeral Chapel, P.A.

11605 Reisterstown Rd., Owings Mills, Md. 21117 21. Signature of Foreral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chanc Obstructive **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 rsing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 → Yo 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Injury at Work? Certification: 5 ☐ Pending investigation Injury atural 1 ☐ Yes 2 ☐ No ours after death. neral Director: A filled in by the fu 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D47683 27/28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymond Miller 25 Main Sorrer Sinte Renterbur 200 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		For State Registrar	State	of Maryland / Dep Ce	ertificate of			nental H	ygier Reg. N		80	2750
Physici	an	1. Decedent's Name (First, Mid Laura C. Green						2. Date of D Month	eath		Year	3. Time of Death
/Medi Examir	cal	4a. Facility Name (If not instituti		umher)	4b. City, Town, o	or Location	of Death	8	32 4	c. County o	t Death	7:59 A
Examin	ier			F BALTIMOR	_			ty		c. County o	Death	
Funeral Director		5. Social Security Number 218-78-0346	6. Sex 1 ☐ M 2√ExtF	7. Age (In yrs. last birthda	Months Days	If Under Hours	24 Hrs. Min.	8. Date of B	Day, Yea	r)	9. Birthp Coun	
		Usual Residence of Decedent		75 Yrs.				Oct. 9,	1932	<u> </u>		VA
f shov	ō	MD 10a. State 10b. Count	ty	10c. City, Town or l	ocation Baltimo	re					10	0d. Inside City Limi 1∰XYes 2⊟N
a or 28a-	Funeral Director	10e. Street and Number 2902 Belmont Ave	enue		10f. Zip Code	2121	6		10g. C	Citizen of Wh	nat Count US/	try?
Hygiene. Hygiene. ther whatural", or items 23a or 28a-f showent, its madical Evaring must be rollf of a	þ	11. Marital Status  ★★ Never Married 2 Ma 3 Widowed 4 Divorce	Armed Fo arried 1 ☐ Yes If Yes Gi		. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2√√No	Hispanic Or an, Mexica Specify		ecify Yes or N Rican, etc.)	lo-	14. Race Black, Specify:	White, e	itc.
iene. than "natural", the involced Evo	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	ent's Education lest grade completed)	16a. Dec	edent's Usual Occup e kind of work done DO NOT use retired	during mos	st of work	<sub>ing</sub> unk	16b.	Kind of Busi	iness/Ind	lustry U <b>nk</b>
Mental Arked o	To Be C	17. Father's Name (First, Middle Albert	, Last) Green			18. Moth	er's Nam	e (First, Middle Lottie	,	,	)	
th and traums		Joseph Lewis / b			ing Address <i>(Street</i> <b>Belmont Ave</b> i				ber, City 2121		tate, Zip	Code)
populari i agos i and z Important: If Item 27 Is any Injury or other tra once.		20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other place			Date PID		Location - C	ity or To	wn, State
tment tant; If jury or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		Mount Zion	Cemetery		08/30		Balt	imore,	Mary!	land
Depar Impor any In once.		21. Signature of Funeral Se vice	e Licensee		22. Name and Addre							17
		23a. Part . wer the disease, o	or complications that of		638 N. Gilm nter the mode of dyir					irytand	212	Approximate Interval Between
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) physician and s the burial-transit		,	d.	or as a consequence or,								
/ the attending ph ched for use as th	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ∐Yes 2√√No 9 ∐Unknown	1 ☐ Live t	nant at time of death 5	☐ Ectopic pregnanc	у			J	23d. Date Mont		ry Day Year
signed by the aid be detached f	y Ph	Part II. Other significant condit	ions contributing to de	eath but not resulting in the I	underlying cause give	en in Part I		23e. Did	tobacco	use contrib	oute to the	e cause of death?
CD W	ted							10	Yes 2	2 No 3	☐ Proba	ably 4 🗆 Unknow
een sig nould be	Completed							24a. Was	s an opsy ormed?	pri	ere autop or to con ath?	esy findings availab apletion of cause of
has been sig ge 2 should be		25. Was case referred to medica	al .			26 Place	of Dootl	1 ☐ Yes	2 🖳 Ñ	0 1	Yes	2 □No
as beer 2 shoul			I I a a a it a it	npatient 2 ER/Outpatie	nt 3 DOA Othe			me 5 ☐ Res		6 ☐Other	(Specify	)
his certificate has been sig I director, page 2 should be	Be	examiner? 1 ☐ Yes 2 ☑ No		of Injury 28b. Time of	of 28c. Injury	y at		28d. Describe	how inju	ury occurred	l	
n. After this certific funeral director, I	Be	1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	ng 28a. Date (Mont	th, Day, Year)	Work						or Rural	D
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